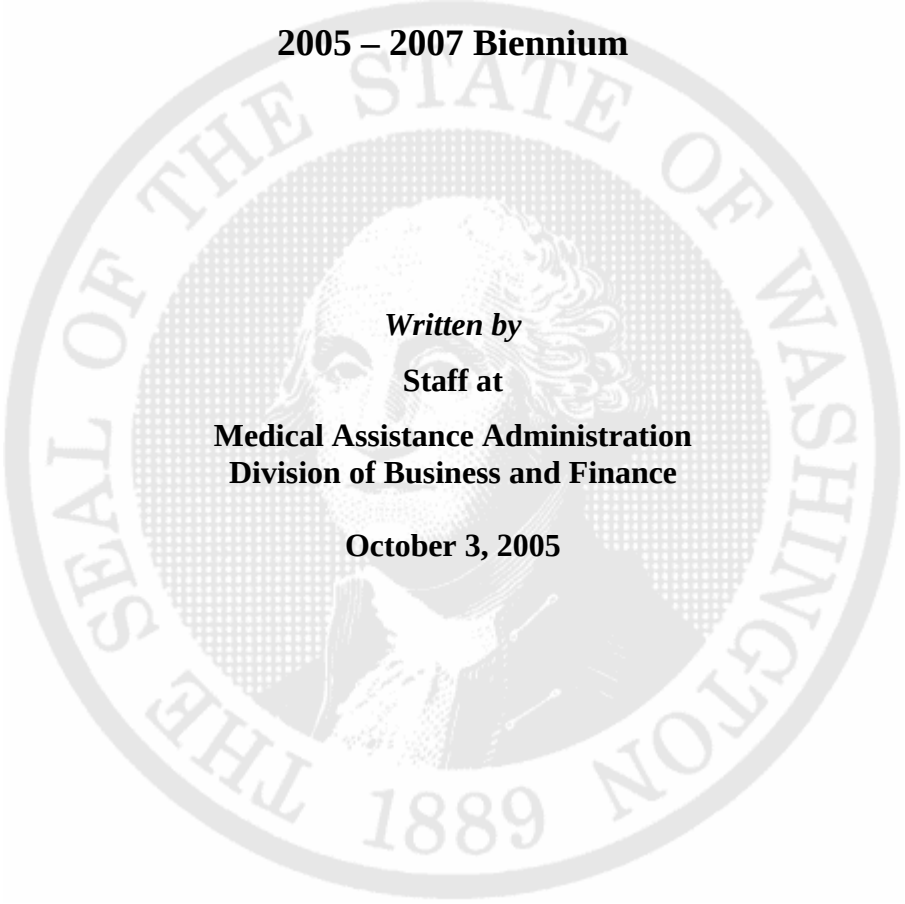
Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

2005 – 2007 Biennium



Written by

Staff at

Medical Assistance Administration
Division of Business and Finance

October 3, 2005

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PURPOSE

The Centers for Medicare and Medicaid Services (CMS) has mandated that Washington State stop existing intergovernmental transfer (IGT) programs as of June 30, 2005. IGT programs include Disproportionate Share Hospital (DSH) payments and Upper Payment Limit (UPL) payments that involve making payments to hospitals which are returned to the State for spending by the State. IGT transactions net $80 million in revenue to the state. This revenue is spent on health care for low income persons who do not meet Medicaid eligibility requirements.

The Legislature and CMS have approved a program to replace IGTs that uses Certified Public Expenditures (CPE) to earn federal Medicaid funds for inpatient claims and DSH payments to certain public hospitals. These hospitals will be required to certify their qualifying expenditures that will be used to draw federal Medicaid funds according to the federal rule on the issue, 42 CFR 433.51.

This manual provides information on the structure, operation, policies and authorization of the CPE program in Washington State. It is one of the "policy provisions … department numbered memoranda, billing instructions, and other associated department issuances" incorporated by reference into the Core Provider Agreement and the Interlocal Agreements between the Department and participating hospitals.

Acknowledgements
Many thanks to the Washington State Hospital Association staff, Medical Assistance Administration Finance staff and to Covington and Burling attorneys for their assistance in creating this manual.

BACKGROUND

As long ago as 1991, agencies within the Federal Government raised questions about the practice of IGTs. Although IGTs are operated within federal law and rule, the perception is that some of these practices inappropriately increase federal reimbursement in the Medicaid program. Two aspects of IGTs are thought to be inappropriate. First, IGTs may inappropriately increase the amount of federal funds a state receives by claiming payments that are not retained by hospitals. Second, IGTs may introduce "recycling", wherein a state uses the federal funds received from IGTs to match federal funds a second time. Washington State used IGT revenue to fund health care services for low income persons, including those on General Assistance-Unemployable, the Medically Indigent Program and the Basic Health Program.

CMS implemented a process whereby any State Plan amendment (SPA) submitted must have five questions answered before it could be considered for approval. The five questions dealt with, among other things, the allowability of IGTs being used by the submitting state. Specifically, questions attempted to identify whether the providers involved in IGTs kept funds they received and what was the source of state funds that were used to draw federal match. States were also asked to provide this information in a congressional investigation led by Senator Barton.

In April 2004, CMS provided information on the approach to IGTs in a letter to Senator Grassley from Iowa. In the letter, CMS stated their approach to IGT allowability as follows:

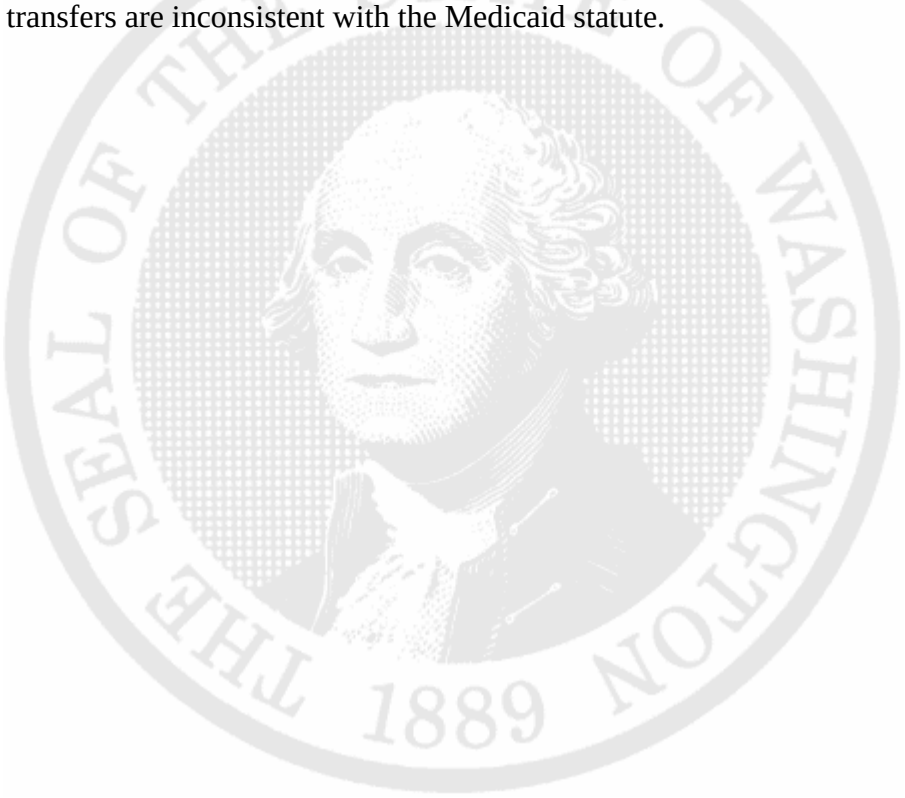
> "We distinguish a true, protected IGT, in which a state shares its cost of the Medicaid program with local units of government through tax revenues or certified public expenditures (CPEs), from an unprotected "recycling" mechanism under which payments to providers for services are returned to the state. "Recycling" has the effect of shifting the cost of the program from state/local governments to the Federal Government, thereby increasing the Federal match rate. A true IGT does not have this effect."

In the summer of 2004, CMS notified Washington State that a commitment needed to be made in the Medicaid State Plan to stop IGTs as of June 30, 2005. CMS indicated that no hospital related State Plan Amendments (SPA) would be approved unless and until this commitment was made and approved by CMS.

At the time this mandate was conveyed, Washington State had a SPA pending approval with CMS that allowed the State to utilize the temporary provision for DSH spending at 175% of the normal state limits. This provision was assumed in the State's budget and it would provide the State with funding for health care. Without this provision, a large deficit in the State budget would have been much bigger. This necessitated action on the pending SPA.

Washington State developed an alternative reimbursement mechanism to offset some of the loss of funds resulting from IGT elimination. This proposal was submitted in the same SPA that committed the State to stopping IGTs as of June 30, 2005. The SPA was submitted in January 2005 and approved by CMS on April 20, 2005. The new program (called the CPE program) is mandated to take effect July 1, 2005.

Through approval of the State Plan Amendment for Washington State, CMS has affirmed that CPE is fundamentally different from the previous methodology, IGTs. The essential difference between CPEs and IGTs is the potential to create "recycling". Recycling alters the statutory match rate by leading to a "net expenditure" that is less than the nominal payment to a provider. In order to earn a federal matching payment based on certification, there must actually be an outlay of funds by the provider for Medicaid-eligible activities. By contrast, the ability to use IGTs to make payments to providers that are entirely offset by transfers of funds to MAA is what has caused CMS to conclude that these transfers are inconsistent with the Medicaid statute.



PROGRAM AUTHORITY

Authority for the CPE program has two distinct parts – a federal authority and a state authority. Each authority deals with different aspects of the program, although the two may overlap in some areas. The two parts of the CPE program necessitate different policies and procedures to address each set of requirements adequately.

Federal Authority
Federal authority for the CPE program is contained in the SPA approved by CMS. See Appendix C for a complete copy of the SPA. The federal approval includes direction regarding how inpatient hospital claims are paid under the CPE program, how DSH is paid under the program, where certified public expenditures are relied upon to claim federal match, and how certification of public funds is completed. The State Plan contains the federal portion of the CPE program.

State Authority
The state portion of the CPE program is authorized by ESSB 6090, Part II, section 209(9), the 2005-2007 Biennial Operating Budget. This budget language is contained in Appendix A. The Operating Budget contains the state portion of the CPE program, which authorizes payment according to the CPE program methodology. The state portion of the program also includes a provision that hospitals in the program will be paid at least as much as they would have under the previous payment methodology (the "hold harmless" provision) and a requirement that hospital payments not be disallowed if hospitals follow the State's direction on participation in the program. The budget authorizes payment of new grants from state general funds to ensure that the hold harmless provision is implemented.

Certification
The certification of public expenditures is governed by a federal rule, 42 CFR 433.51. This rule is reprinted in Appendix B. Certification of public expenditures is a federal authority and a federal requirement. No additional requirements are mandated by the State authorization for the CPE program, which means that the certification letter signed by hospitals will only address the federal requirements of the CPE program. The hospitals are expected, however, to follow the Department's guidance on certification of public expenditures.

PROGRAM DEFINITION

The CPE program is a payment methodology that applies to public hospitals that do not have Critical Access Hospital status, including those hospitals that are owned or operated by the State. The program's payment methodology applies to inpatient hospital claims, to the payment of Disproportionate Share Hospital (DSH) payments, and to state grants. The program also includes upper payment limit (UPL) payments for one hospital.

Under the program, hospitals are paid at an estimate of the cost to provide services to Medicaid recipients or for uncompensated care. The estimate of costs for inpatient claims is calculated as a ratio of cost to charges (RCC) calculated using a base year, usually two years before the service year. DSH payments are made at the hospital's limit, as calculated according to federal requirements. For each payment to a hospital in the program, only the federal matching portion of the payment is remitted to the hospital; the state portion is funded through certified public expenditures.

The total payments hospitals receive under the sum of the program payment components are guaranteed to be at least an amount called the "baseline". The baseline is the amount the hospital would have received if the CPE program had not been enacted and the previous payment methodology and state plan and waiver provisions had not been discontinued. The hospital will receive the baseline or the full cost of services rendered under MAA programs, whichever is higher. In the event there is a shortfall between the payment components noted above and the baseline, the difference is paid to the hospital with state funds, in the form of a grant. For Harborview Medical Center (HMC), which receives a UPL payment, the UPL payment is calculated at the full amount the hospital can receive under federal rules. Federal matching funds are paid in addition to state funds for the full payment amount. In the event of a shortfall between the CPE program component payments and the baseline, the difference is paid to HMC with state grant funds.

EFFECTIVE DATE OF PROGRAM

The CPE program was enacted as of April 24, 2005 by the Washington State Legislature. It was signed by the Governor on May 17, 2005. The State Plan Amendment was approved by CMS on April 20, 2005. In both documents, the program is mandated to begin July 1, 2005.

The state budget mandates that "the department is directed to implement the inpatient hospital certified public expenditures program for the 2005-07 biennium". There is no plan in place for replacement of the CPE program should the program not be reauthorized.

Regardless of whether the program is continued, the hold harmless requirement relating to service years in which the program is in effect must be adhered to, even though the information needed to complete hold harmless calculations is not available until after the service year is complete.

HOSPITALS IN THE PROGRAM

The program includes all public hospitals, including those owned or operated by the state, except those classified as critical access hospitals or state psychiatric institutions. As of July 1, 2005, this includes the following hospitals:

Cascade Valley Hospital	Evergreen Hospital Medical Center
Harborview Medical Center	Kennewick General Hospital
Olympic Medical Center	Stevens Health Care
Samaritan Hospital – Moses Lake	Skagit County Hospital District #2 – Island
Skagit Valley Hospital – Affiliated	Snoqualmie Valley Hospital
University of Washington Medical Center	Valley General Hospital - Monroe
Valley Medical Center - Renton	Whidbey General Hospital

HOLD HARMLESS PROVISION

The CPE program has a state mandate for a hold harmless provision. This provision is stated as follows in the State Operating Budget:

> "The legislature intends that hospitals in the program receive no less in combined state and federal payments than they would have received under the methodology that was in place during fiscal year 2005."

Under this provision, each hospital must be paid at least as much money by the State as they would have received under the methodology in place in 2005 – including RCC, DRG, selective contract, or whatever combination of methodologies were used to pay the hospital. The amount of money equal to "what the hospital would have been paid" is referred to herein as the "baseline".

To ensure that the hold harmless provision is complied with, a process is in place to create an interim baseline for use in making payments during the service year. This baseline will be updated once all necessary actual data and information is received for a final hold harmless calculation. The hold harmless calculation will be completed at the same time that the federally required prospective cost settlement is calculated.

BASELINE DEFINITION AND CALCULATION

The baseline is the minimum amount the hospital must receive under the CPE program – state law requires that the hospital receive no less. Baseline is also the amount that will be calculated as the total amount the hospital would receive under the program – the intent is that the baseline is the "floor" for payment under the program. Any payments over baseline would be paid to the hospital as federal Medicaid or DSH payments calculated under the full cost methodology required under Certified Public Expenditures.

Due to delays in billing inherent in the inpatient hospital payment process and to delays in receipt of cost reports and financial statements, definitively identifying the actual amount that a hospital would have received under a different payment methodology than the one in place is not possible until over a year after the end of the service year. This can be problematic, since hospitals need funding provided for Medical Assistance patients in order to operate. To deal with these issues, the concept of an interim baseline used during the service year, a current year revised baseline and a final baseline are used to ensure that the hold harmless mandate is complied with and incorporated into the CPE program design.

Interim Baseline

The interim baseline is calculated prior to the start of the service year using a recently completed expenditure year trended forward. A year of expenditures for each hospital is used as the basis for the calculation. This year is two years prior to the service year in question (eg. For 2006, 2004 will be used to calculate the interim baseline). All inpatient expenditures for that year are captured and the costs and payments inherent in the data are trended forward. Costs are trended forward using historical cost increases over the most recent two years for Washington State hospitals. DSH payments from the State net of IGTs received by the hospitals in 2005 are included in the baseline. Any changes from the historical patterns shall be worked into the projection separately. This may include a payment policy change, a reduction or increase in state payments, or other change that would affect the hospital's payment level.

The interim baseline is calculated in the fall of each year, in preparation for the Governor's budget. The calculation of interim baseline will be completed by the State and sent to each hospital for review and appeal no less than eight weeks before submission of the Governor's budget proposal to the Legislature. Each hospital will have the opportunity during that time to present information, data and analysis to the state if they disagree with the calculation of the interim baseline. This information will be presented to the Director of Finance for Medical Assistance Administration. If, after review and discussion, the hospital is not satisfied with the State's determination of the interim baseline, it can appeal to the Medical Assistance Administration's Deputy Assistant Secretary. These appeals should occur within the eight-week period of time before submission of the Department's budget

February Update's Impact on Supplemental Budget, Interim Baseline and Final Baseline
Each February, HRSA will update the interim baseline for forecasted changes in current program costs and payments. As part of the current year supplemental budget development process, participating hospitals will be requested to submit claims information, uncompensated care cost and other information related to current year activity. HRSA will use this information to update the interim baseline calculations and related state grant payments for the current service year. HRSA will include this information in the department's current year supplemental budget request.

In the event that legislative policy changes are enacted MAA will make required adjustments in the current year baseline calculation, budget submission and payments to participating hospitals.

Each February, HRSA will estimate the final baseline for the prior year. As part of the current year budget development process, participating CPE hospitals will be requested to submit claims information, uncompensated care costs and other information related to prior year activity. HRSA will use this information to estimate final baseline calculations and related state grant requirements for the prior service year. HRSA will include this information in the department's current year supplemental budget request. This process will allow state grant payments to be made as close as possible to the actual period in which services are delivered. All remittances and recoupments of state grant payments will be determined by final baseline calculation typically completed in April of each year (see description of final baseline below).

Final Baseline
The interim baseline can only be finalized after all inpatient claims for the service year are paid. On average, this information would be complete and received by MAA approximately ten months after the end of the service year. MAA will utilize a programming model to determine how each claim would have been paid under the methodology in place before CPE went into effect. After repricing of actual paid claims, HRSA will recalculate the e o baseline. and update the state grant payment required to meet hold harmless requirement.

All payments under the CPE program (including the prospective cost settlement amounts) are compared to the baseline to determine if the hospital's funding is sufficient to meet hold harmless requirements. If the funding is too low, the state grant amount that the hospital receives is increased. If it is too high, the state grant amount is reduced. MAA will include any mandated change in funding requirements in their next supplemental budget request.

The state grant payments will be adjusted again upon calculation of the prospective cost settlement.

Cost Settlement and Final Comparison to Baseline
Financial Statements and the Medicare cost report are used to complete the federally required prospective cost settlement (see "Prospective Cost Settlement" below). MAA

can complete the prospective cost settlement after the final (audited) Medicare cost report and audited financial statements are received. The hold harmless calculations are completed after the prospective cost settlement is complete for a given service year, to ensure that any prospective cost settlement amounts are taken into account in the hold harmless calculation. The final adjustments are made to the state grant amount upon calculation of the cost settlement.

Recoupment or Remittance Resulting From Changes in State Grant Payments:
If a Hospital is determined to have received an excess or insufficient state grant payment under this program, due to cost settlement calculations, the next year's state grant amount will be adjusted for the change.

PROGRAM PAYMENT POLICIES

Payment is calculated according to the following methodologies in the CPE program.

Inpatient Claims
Under the CPE program, hospitals will submit claims for inpatient services provided to Medicaid and state-only program enrollees as they have in the past. The claim form, information on the claim, and information submitted with the claim, will not change under the CPE program.

The allowable and payment for each claim will be calculated as follows when the claim is received by the department and approved for payment:

(1) *Allowable for the Claim = (Covered Charges x RCC)

(2) Payment for the Claim = [(Allowable for the Claim) – (Client Responsibility/TPL) x FMAP]

*One exception to the calculation methods shown above is the allowable and payment calculations for state-only program inpatient psychiatric claims with admit dates on or after August 1, 2005. The "Base Community Psychiatric Hospitalization Payment Rate" is considered when calculating the allowable for claims having an admit date on or after August 1, 2005, whose "root cause" are found by the department to be psychiatric.

For these claims the allowable and payment for each claim will be calculated as follows when the claim is received by the department and approved for payment:

(1) *Allowable for the Claim = the greater of [(Covered Charges x RCC) or ("Base Community Psychiatric Hospitalization Payment Rate" x **Allowed** Length of Stay)]

(2) Payment for the Claim = [(Allowable for the Claim) – (Client Responsibility/TPL) x FMAP]

Each term is defined as follows:
Allowable – the calculated amount allowed for the claim prior to removing client responsibility and third party liability amounts before payment.
Charges – the covered charges submitted on the claim
RCC – the ratio of cost to charges calculated for the hospital submitting the claim. The RCC is calculated from the Medicare Cost report that is approximately two years older than the service year the payment is made for. Use of this prospective RCC means that the payment to the hospital is an estimate of cost. The CPE program requires that payment be full cost, necessitating a prospective cost settlement (see "prospective cost settlement", below)

FMAP – federal matching assistance percentage. This is the percent of federal match received by the state for any expenditure under the Medicaid program. For Washington State, the percentage has been 50% for many years; the percentage may be changed by the federal government each year.

Eligibility programs that will have claims paid using the CPE methodology include Medicaid, Medicare cross-over, General Assistance-Unemployable (GAU), Alcohol and Drug Abuse Treatment Services Act (ADATSA), Psychiatric Indigent Inpatient (PII). Only claims for inpatient hospital services are paid using the CPE methodology.

Certain payments are not paid in this manner, including trauma enhancement payments, and Monthly Healthy Options-related Graduate Medical Education (GME) payments paid to the Harborview Medical Center and the University of Washington Medical Center. These payments are paid in full (both the federal and the state portion are remitted).

Payments for these claims are tracked by the State's Medicaid Management Information System (MMIS) on a date-of-service basis. Since all claims information is tracked in MMIS, the State can provide information to hospitals necessary for the certification process (see "certification of public funds", below).

DSH

The department will continue to calculate each hospital's individual DSH limit in the same manner as it is now calculated, with a reasonable trend assumption for increases in uncompensated care. For hospitals in the CPE program, the amount available under the limit multiplied by the FMAP will be paid out on a monthly basis, with $1/12^{th}$ of the limit paid each month at the end of the month. CMS requires that payments for DSH and UPL are made after qualifying care is provided as much as possible, requiring that payments be made at the end of the month.

The payment methodology is shown below:

DSH Limit / 12 x FMAP = Monthly Payment

Hospitals in the CPE program will not receive any funds from other DSH programs. The other DSH programs (Low Income DSH, Small Rural DSH, Rural and Urban Medically Indigent Offset DSH) will be reduced in size for the amount of funding that these programs historically paid to the hospitals in the CPE program.

The facility DSH limit calculation is usually completed in September of each year. Payments for up to the first three months of the fiscal year will be made using an estimate of the DSH limit to avoid a delay in payments. The estimate will be based on the previous year's DSH limit, with changes for projected uncompensated care and RCC changes. Payments for the remainder of the year will be adjusted if the estimated payment is different from payments pursuant to the DSH limit calculation.

To calculate the DSH limit, many factors are considered. One of those factors is the RCC for the hospital; as with inpatient payments the RCC is based on a year about two years

prior to the service year. Because the CPE program requires full cost payment, the DSH lid will be updated for final RCC and actual uncompensated care in a prospective settlement process (see "prospective settlement", below). Another factor is the sources of uncompensated care for the hospital. Uncompensated care will include the cost of providing care to indigent persons (charity and bad debt), the cost of care for state-only programs and the difference between the cost of care and payments made for outpatient Medicaid services and Medicaid managed care clients. The cost of these components is identified through the DSH application process as set forth in WAC and other directives and the subsequent identification of the DSH facility limit. Note that there is no difference between the cost of care and payments for inpatient services; these services are paid at full cost under the CPE program.

Each hospital in the program will receive the federal portion of the full amount of DSH up to the facility limit, requiring the entire DSH facility limit to be certified as part of the certification process (see "certification of public funds", below).

All DSH funds will be retained by the hospital they are paid to. No repayment of funds via IGT is allowed under the CPE program. This is mandated by the Medicaid State Plan and the Operating Budget.

UPL
Upper Payment Limit payments are made to HMC only. The UPL payment will be calculated at the same time as the interim baseline and hold harmless requirements. The amount of the UPL payment is calculated as the amount necessary to hold HMC harmless for the CPE program. As much as is possible for HMC, UPL payments are made in lieu of state grant payments to bring total payments under the CPE methodology up to the baseline amount. Payments will be made on the same basis as DSH payments, except that UPL payments must have state funds as match – CPE is not allowed for these payments. For hospitals in the CPE program, $1/12^{th}$ of the total amount available under the limit multiplied by the FMAP will be paid out each month at the end of the month.". CMS requires that payments for DSH and UPL are made after qualifying care is provided as much as possible, requiring that payments be made at the end of the month.

State Grants
During each year's budget preparation process in the fall, a projection of the amount payable by the state to each hospital under the methodologies identified above for the current and the next year is compared to the baseline calculated according to the methodology stated previously. The difference between the baseline and the projected payments is required to be paid to the hospital in the form of a state grant. The state grant amount will be identified for inclusion in the Department's budget proposal, and then in the Governor's budget. The state grant amounts are set in the enacted state budget for the next two years. They may be updated twice, in each year's supplemental budget. These are the amounts sent out to the hospital to satisfy the hold harmless provision in the CPE program. The State Grant amount provided in the biennial budget will be paid out in July of each year in total. When the grant amount is updated in the Supplemental state budget, the state grant amount will be adjusted, with increases paid out upon signing of the state

operating budget by the Governor and decreases being recouped or offset against hospital payments upon signing of the budget. State grant decreases will be recouped in one payment request, unless the hospital contacts MAA and negotiates recoupment over a period of time or deduction from claims payments. All recoupments and payment reductions must be complete by June 30 of the year in which they are identified.

For a detailed timeline of baseline calculations and state grant payments, see below under "program payment and reconciliation timeline".

Length of Stay Reviews
Under federal regulations, utilization review is a necessary part of cost control measures in the Medicaid program. In Washington, length of stay review is governed by WAC 388-550-4300, which states that claims paid under the RCC methodology will be reviewed for length of stay requirements before payment is made.

Under the CPE program, all claims are initially paid RCC. The hold harmless calculation converts these payments to the reimbursement methodology that was in place prior to the start of the CPE program. The CPE program's intent is to maintain payments to participating hospitals at the same level as existed under the previous DRG/RCC payment system. Accordingly, DSHS will apply the same UR criteria under the CPE program as applied under the previous DRG/RCC payment system.

In general,

- DSHS will to continue apply the same review criteria under CPE program as applied to DRG/RCC paid cases during SFY05.
- Review of claims will be on a post pay basis, rather than on a pre-pay basis as has been the policy prior to July 1, 2005.
- Hospitals will retain the same appeal rights as existed under previous DRG/RCC payment system.
- Settlement of appeals that result in denial or payment will be incorporated into the hold harmless calculation as a payment that would have been made under the old methodology – they will be incorporated into the baseline calculation and into the CPE payment calculation.

Specifically, for admissions beginning on or after July 1, 2005 and for the duration of the CPE program:

<u>Claims previously paid based on DRG</u>
Claims that would previously have been paid based on the DRG payment methodology will not be reviewed for medical necessity per existing WAC 388-550-4300.

<u>Claims previously paid based on RCC</u>
Claims that would previously have been paid based on the RCC payment methodology will be reviewed for medical necessity per existing WAC 388-550-4300. Claims will be selected for review based on the number of days established at the seventy-fifth percentile in the current edition of the publication, "*Length of Stay by Diagnosis and*

Operation, Western Region." (3)(a-c). Medical necessity will be established based on InterQual admission criteria in effect at the time of admission.

Claims review will be on a post pay basis. DSHS will deactivate the MMIS claim edit for RCC paid cases to ensure that claims are paid prior to length of stay reviews. Hospitals will not be required to submit information prior to the claim payment. Claims reviews will occur after payment, but before the calculation of hold harmless amounts under the CPE program. From the cases selected, DSHS will identify and report to the provider those claims being denied based on lack of sufficient documentation to support medical necessity at the time of admission. For each denied claim, DSHS will provide hospitals with patient/claim level identification, a description of specific InterQual medical necessity criteria not met, the amount of charges/days denied and the amount of any recoupment.

CERTIFICATION OF PUBLIC FUNDS

Certification of public funds will take place on an annual basis, approximately nine months after the end of the service year being certified.

Certification Amount
The amount each hospital must certify is equal to allowed CPE charges multiplied by the applicable RCC for each paid claim in the categories listed above under "inpatient claims" and "DSH". The allowable CPE charges will be determined using the charges for "inpatient claims" and "DSH" described above. A full year's expenditures must be certified, since the certification is completed annually.

Since the claim amounts in the above categories are contained in the MMIS and in the DSH applications submitted by each hospital to MAA, each of the claim amounts in the categories above will be identified by MAA – the Medicaid inpatient claims amount through MMIS data and the DSH facility limit. These amounts will be incorporated into the certification letter that will be sent to each facility for signature. Details of these amounts will also be sent to each hospital for documentation, review and verification. If any amounts are incorrect, the hospital must contact the CPE program coordinator before signing and returning the certification letter.

Certification Requirements
The federal rule that governs the use of CPE by states is contained in Appendix B.

The rule authorizes public institutions – including hospitals that are owned or operated by public entities (and are designated as "public") – to use expenditures at the institution as the state share in claiming federal Medicaid funds, including DSH funds. The designation of a hospital as "public" must be approved by CMS. In Washington's case, CMS has reviewed and accepted the list of hospitals set forth on page 9 as eligible to certify expenditures.

Certifiable expenditures include all expenditures used to serve Medicaid eligible patients or uninsured indigent patients. The manner of determining certifiable expenditures is discussed below.

Discrete federal grant funds cannot be certified as CPE. These funds generally cannot be used as the basis for earning more federal funds, unless the grant authorization specifically permits this. For the most part, this clause will not have any impact on hospital CPEs. But to the extent that a hospital's revenues include federal grant funds (for example, Hill-Burton funds), the hospital needs to be sure that there are other sources of revenue sufficient (including Medicaid payments from the State) to cover the expenditures that are being certified. Note that federal Medicaid funds are an appropriate source of funds used to pay for expenditures to be certified, since these represent reimbursements of outlays made by the State Medicaid agency (or by the certifying public provider). Therefore, if the hospital has sufficient cash flow (exclusive of Hill-

Burton or other federal grant funds) to provide care to Medicaid and indigent patients, the requirement of the federal rule is met.

CMS has not provided specific guidance on whether other specific types of funds are allowable as public expenditures, except that certified public expenditures cannot be based on provider taxes or donations that are impermissible under section 1903(w) of the Social Security Act. Legal analysis indicates that there is no basis for limiting public expenditures to tax revenues or other narrowly defined fund sources. Legitimate sources of certifiable expenditures would include subsidies received from state, county or local governmental entities, income earned from operations of the hospital or of allied activities (e.g., parking lots, gift shops, restaurants that are part of the hospital enterprise), contributions from members of the public, grants from foundations or other grant-making organizations, and tolls, tuitions, gate receipts, and other revenue sources available to a state or local governmental department or agency that are made available to the hospital to fund its operations. Any funds legitimately earned by or provided to the public hospital should be treated as public when used to make expenditures in support of the hospital's operations.

Certification Timeline and Letter

The certification will be completed on an annual basis for each hospital. Certification will be made approximately ten months after the end of the service year being certified, once inpatient claims are substantially paid. At the time of certification, MAA will collect the data necessary for certification and place the information in the standard letter. The Chief Financial Offices will sign and return the certification letter to the CPE coordinator at MAA.

The certification letter to be used is contained in Appendix E. Note that the letter deals only with the federal requirement for certification of matching Medicaid funds. It does not have any connection with the state mandate for a hold harmless mechanism, nor does it discuss the payment of state grants. This does not mean that these provisions are not in effect, only that this particular letter is for a narrow, discrete purpose – the certification of public expenditures used to obtain federal funds as match.

PROSPECTIVE COST SETTLEMENT

Prospective cost settlement has two aspects – a federal requirement and a state mandate.

Federal Settlement Requirements
The federal rule governing the use of CPE (reproduced in Appendix B) mandates that federal funds are used to match the full cost of services provided under the program. To ensure that this requirement is met, CMS approved the State's SPA with the understanding that a prospective cost settlement would be included. The cost settlement is intended to ensure that full cost is used as the basis for reimbursement in the CPE program.

Prospective cost settlement was agreed to as a way to ensure a full cost basis in the program and to avoid recoupment of federal money years after a payment is made. Prospective settlement affects the RCC used to make payments and the amount of uncompensated care a hospital incurred during the service year. The settlement will be performed twice – once using the "as filed" Medicare Cost Report (form 2552) and a second time using the audited*, or final, form 2552. When the "as filed" form 2552 for the service year is received (about four months after the service year), the RCC will be recomputed by MAA based on the service year's cost data. If the prospective RCC used to make payments during the service year is too high, the RCC for the next year would be lowered to offset this overpayment. If the prospective RCC was too low, the RCC for the next year would be increased to offset the underpayment. Similarly, uncompensated care for the service year will be compared to uncompensated care used in the DSH limit calculation. If uncompensated care was higher than the prospective estimate, the next year's DSH limit will be increased, and vice versa. These changes ensure that the hospital receives actual full cost reimbursement related to the service year. This calculation is repeated when the audited form 2552 is received at MAA. Any changes are prospectively reflected in the next year's RCC and/or DSH payments. This final reconciliation occurs approximately two years after the end of the service year.

* The audited cost report is defined as the Medicare Cost Report form 2552 that has been desk reviewed and audited by the fiscal intermediary. This is the report that the Notice of Program Reimbursement (NPR) is based on. Any appeals have not been filed on the audited cost report.

State Settlement Mandate
To ensure a complete implementation of the state hold harmless mandate, a final baseline calculation is completed once the claims data for the service year is complete (ten months after completion of the service year). A final adjustment to the hold harmless calculation, i.e. state grant requirement, is done at the time that the federal prospective cost settlement is completed.

The final baseline uses actual inpatient claims data from each hospital during the service year and calculated DSH payments from fiscal year 2005. A programming model that calculates the inpatient payments for the hospital that would have been made if the CPE

methodology had not been in place is used to calculate the baseline amount for inpatient payments. DSH and UPL payments that would have been calculated and paid to the hospital if CPE had not been in place are also calculated (including retained amounts from IGTs in effect in State Fiscal Year 2005). The total of these amounts constitutes the final baseline.

The baseline amount is compared to the actual amounts the hospital received under the CPE program. If the baseline is higher than payments under the CPE program, additional state grant funds are paid to satisfy the hold harmless requirement, upon appropriation by the legislature. Conversely, if the baseline is lower than payments under the CPE program, the overpayment of state funds is recouped. This calculation occurs after the claims history is complete, approximately ten months after the end of the service year. In order to request funding necessary to adjust state grant payments, MAA will request information from hospitals on claims related to the service year that are in process but not yet paid. This request will be made about January of each year.

A second adjustment for the state hold harmless mandate is made at the time the federally required prospective cost settlement is completed. The state grant amount is adjusted upward or downward to offset the impact of the prospective cost settlement, to ensure that hospitals are held harmless from the effect of the settlement.

Example
An example is shown below.

Information for one hospital in the CPE program:

Service Year:	2006	Interim Baseline:	$850,000	
Final Federal Settlement Year:	2008	Prospective RCC:	.58	
Payment Adjustment Year:	2009	DSH facility limit:	$200,000	

During 2006, payments to the hospital were as follows:

Inpatient Payments	$350,000	
DSH Payments	$200,000	
State Grant Payments	$300,000	
Total Payments		$850,000
Difference from baseline:	$0	

In May, 2007, claims data for the service year is complete. The final baseline and adjusted state grant payments are made, as follows:

Final Baseline	$875,000	
Payments during 2006	$850,000	
Additional state grant		$25,000

In 2008, the final prospective settlement is completed, as follows (note: this calculation is the same for the interim settlement):

Cost report and Financial Statement show -			
Actual RCC:	.55		
DSH limit:	$205,000		
Resulting Actual Payments Should Be:		Effect on 2009 Payments:	
Inpatient Payments	$335,000	Reduce RCC by an amount netting $15,000	
DSH Payments	$205,000	Increase DSH payments by $5,000	
State Grant Payments	$335,000	Increase State Grants by $10,000	
Total Payments	$875,000		
Difference from Baseline:	$0		

For the service year 2006, the prospective RCC was higher than the actual RCC, resulting in an overpayment of federal funds for inpatient services. This results in a reduction of the next year's RCC by the amount necessary to adjust for the overpayment. Uncompensated care was higher than the interim projection, resulting in an increase in DSH payments for 2009. State grants are increased to the amount necessary to meet the final hold harmless requirement for 2006. Note that the final change in state grant payments takes into account the grant payment made in 2006, and the adjustment to the state grant made in 2007.

Note also that the prospective cost settlement does not affect the hold harmless mandate. If federal funds paid out during the service year were too high and this resulted in a future year reduction in federal payments, the hospital's state grants must be increased to offset the loss of revenue, up to the baseline amount. In the calculation of state grants (discussed above in "Program Payment Policies – State Grants") the projected payment to the hospital will include any prospective cost settlement adjustments, so that when compared to the baseline the actual payments to the hospital are accounted for.

Termination of CPE Program

In the event that the CPE program is terminated, the final baseline calculation and prospective cost settlements must be completed. Final baseline calculations are completed within one year after the service year and prospective cost settlements are calculated as the Medicare Cost Report audits are finalized and issued. This means that payments related to the service year will be ongoing for approximately two to three years after the end of the program, with final baseline payments complete after one year and cost settlements complete after two to three years. Although funding decisions made in the future cannot be determined today, the hold harmless provision in the state budget provides some assurance that the State will consider the basis for the CPE program as it determines how to proceed if the program is terminated.

FEDERAL FUNDS DISALLOWANCE

The State Operating Budget language pertaining to CPE states:

> "In the event that any part of the program including, but not limited to, allowable certified public expenditures, is disallowed by the federal government, the department shall not seek recoupment of payments from the hospitals, provided the hospitals have complied with the directions of the department for participation in the program."

This language guides MAA in the implementation of the program.

If providers follow the State Medicaid agency's direction, the budget mandate above prohibits a recoupment of funds from the hospital by the State. The directions hospitals are to follow for the CPE program are contained in this document, in the State rule (see Appendix D) for the program, in any other applicable MAA/Medicaid WAC and in certification letters to be sent to the hospitals.

CMS reviews and audits all claims made by the states in the Medicaid program (including DSH). These claims are also subject to audits by the Office of the Inspector General (OIG). If the State is found to have claimed Medicaid or DSH funds in violation of federal rules or the Medicaid State Plan, funds improperly claimed would be disallowed. Disallowance means that the State is required to return these funds to the CMS and to correct the condition that led to the disallowance. Disallowances occur after the federal fiscal year is closed – often up to a year or more after the fiscal year being audited.

If there is a disallowance, repayment by the state to the federal government must be made through an adjustment in the following quarterly Medicaid claim. The State is in the position of having to make the repayment independent of whether it decides to pursue recoupment. In the event of a disallowance in the CPE program, the State may update or strengthen its direction to hospitals, but it is prohibited from seeking recoupment from hospitals due to the budget language noted above, unless hospitals were found not to have followed the State's direction on the CPE program.

STAFF CONTACTS

Susan Lucas, Director
Division of Business and Finance
PO Box 45500
Olympia, WA 98504

360-725-1828
lucassl@dshs.wa.gov

Carolyn Adams
Chief, Office of Hospital and Managed Care Rates
PO Box 45500
Olympia, WA 98504

360-725-1854
adamscr@dshs.wa.gov

Annette Meyer
Budget Manager
PO Box 45500
Olympia, WA 98504

360-725-1277
meyeram@dshs.wa.gov

Lillian Erola
CPE Coordinator
PO Box 45500
Olympia, WA 98504

360-725-1877
erolal@dshs.wa.gov

APPENDICES:

A. ESSB 6090, Sec 209(9), 2005-2007 Operating Budget
B. 42 CFR 433.51(6), federal rule on certified public expenditures
C. Medicaid State Plan Amendment 03-011
D. Applicable Washington Administrative Code sections
E. Sample certification letter for public expenditures
F. Baseline Calculation Model Example
G. Program Payment and Reconciliation Timeline
H. Numbered Memoranda and Billing Instruction Sections related to CPE
I. Hold Harmless RCC Rates for FY 2006

Medical Assistance Administration

Washington State Certified Public Expenditures Program

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Appendix A

ESSB 6090, Sec 209(9), 2005-2007 Operating Budget

p. 64 ESSB 6090.PL sec. 209(9)

(9) In response to the federal directive to eliminate intergovernmental transfer transactions effective June 30, 2005, the department is directed to implement the inpatient hospital certified public expenditures program for the 2005-07 biennium. The program shall apply to all public hospitals, including those owned or operated by the state, except those classified as critical access hospitals or state psychiatric institutions. Hospitals in the program shall be paid and shall retain (a) one hundred percent of the federal portion of each medicaid inpatient fee-for-service claim payable by the medical assistance administration; and (b) one hundred percent of the federal portion of the maximum disproportionate share hospital payment allowable under federal regulations. Medicaid fee-for-service claim

p. 65 ESSB 6090.PL sec. 209(9)

amounts shall be established by applying the department's ratio of costs to charges payment methodology. The department shall provide participating hospitals with the information and instructions needed by the hospital to certify the public expenditures required to qualify for the federal portions of both the medicaid inpatient fee-for-service payments and the disproportionate share hospital payments. In the event that any part of the program including, but not limited to, allowable certified public expenditures, is disallowed by the federal government, the department shall not seek recoupment of payments from

the hospitals, provided the hospitals have complied with the directions of the department for participation in the program. The legislature intends that hospitals in the program receive no less in combined state and federal payments than they would have received under the methodology that was in place during fiscal year 2005. The department shall therefore make additional grant payments, not to exceed the amounts provided in this subsection, to hospitals whose total payments under the program would otherwise be less than the total state and federal payments they would have received under the methodology in effect during fiscal year 2005. $37,034,000 of the general fund--state appropriation for fiscal year 2006, $37,552,000 of the general fund--state appropriation for fiscal year 2007, $8,300,000 of the emergency medical services and trauma care systems trust account--state appropriation, and $45,450,000 of the general fund--federal appropriation are provided solely for new state grant and upper payment limit programs for the participating hospitals.

Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

2005 – 2007 Biennium

Appendix B

42 CFR 433.51(6)
Federal Rule on Certified Public Expenditures

CPE's

42 CFR 433.51(6)

(2) *Report of refund.* At the end of each calendar quarter, the State agency must identify those checks which were cancelled (voided). The State must refund all FFP that it received for cancelled (voided) checks by adjusting the Quarterly Statement of Expenditures for that quarter.

(3) If the State does not refund the appropriate amount as specified in paragraph (d)(2) of this section, the amount will be disallowed.

[51 FR 36227, Oct. 9, 1986]

Subpart B—General Administrative Requirements State Financial Participation

SOURCE: 57 FR 55138, Nov. 24, 1992, unless otherwise noted.

To share the cost of Medical assistance

§433.50 Basis, scope, and applicability.

(a) *Basis.* This subpart interprets and implements—

(1) Section 1902(a)(2) of the Act, which requires States to share in the cost of medical assistance expenditures and permits both State and local governments to participate in the financing of the non-Federal portion of medical assistance expenditures.

(2) Section 1903(a) of the Act, which requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

(3) Section 1903(w) of the Act, which specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a State's medical assistance expenditures for which Federal financial participation (FFP) is available under the Medicaid program.

(b) *Scope.* This subpart—

(1) Specifies State plan requirements for State financial participation in expenditures for medical assistance.

(2) Defines provider-related donations and health care-related taxes that may be received without a reduction in FFP.

(3) Specifies rules for revenues received from provider-related donations and health care-related taxes during a transition period.

(4) Establishes limitations on FFP when States receive funds from provider-related donations and revenues generated by health care-related taxes.

(c) *Applicability.* The provisions of this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§433.51 Public funds as the State share of financial participation.

(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section. } CPE

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§433.52 General definitions.

As used in this subpart—

Entity related to a health care provider means—

(1) An organization, association, corporation, or partnership formed by or on behalf of a health care provider;

(2) An individual with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act;

(3) An employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or

(4) A supplier of health care items or services or a supplier to providers of health care items or services.

Health care provider means the individual or entity that receives any payment or payments for health care items or services provided.

Provider-related donation means a donation or other voluntary payment (in

CENTERS for MEDICARE & MEDICAID SERVICES

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region II
26 Federal Plaza Rm. 3800
New York, N.Y. 10278

Kathryn Kuhmerker
Deputy Commissioner, Office of Medicaid Management
New York State Health Department
Empire State Plaza
Corning Tower, 14th Floor
Albany, NY 12237

RE: Amendment of Non-emagency Transportation (NET) Waiver

Dear Deputy Commissioner Kuhmerker,

We are in receipt of Madison County's request to participate in the current Section 1915(b)(4) Non-emergency Transportation (NET) waiver for New York, received on July 16,2003. Based upon our review of the waiver amendment as submitted, CMS requires additional information in order to make a determination regarding your request. Please respond to the issues identified below.

Reimbursement Questions Applicable to all Section 4.19B Noninstitutional Services

In light of concerns raised by Congress over state funding of the Medicaid program, we ask that you provide the following information for each of the transportation services reimbursed pursuant to a methodology described in Attachment 4.19B of the State Plan.

1. Section 1903(a)(1) provides that Federal matching funds *are* only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Contracted Entity retains 100 percent of the payments. Does the Contracted Entity retain all of the Medicaid payments and does not participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the Contracted Entity is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid payment for the Contracted Entity is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures

and State share mounts for the Medicaid payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

3. Section 1902(a)(30) requires that payments for services be Consistent with efficiency, anomy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved Stateplan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the Contracted Entity.

4. Do any capitatim payments to the Contracted Entity exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? If so, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Questions Regarding Madison County Waiver Amendment Application

Page 11, Section C. "Selection and Availability of Providers": This section states that the intent is to utilize the current public transportation provider.

How will New York ensure compliance with the open procurement requirements of 45 Code of Federal Regulations, Section 74.43? If the result is a sole source procurement, the State must show how, in complying with the open procurement process, that the end result was sole sourcing.

Pursuant to the provisions of Section 1915(f)(2) of the Social Security Act, a waiver shall be deemed granted unless, within 90-days after the date of its submission, the request is denied or the State is informed in writing of any additional information which is needed in order to make a final determination. Our request for additional information (RAI) stops the 90-day clock for rendering a final decision on whether to approve the State's waiver amendment request. A new 30-day clock will start upon receipt of the State's complete response to our RAI.

Thank you for your prompt attention to these issues. If you have any quasticns regarding this matter, please contact Mr. Michael Melendez with the Division of Medicaid and Children's Health in CMS' New York Regional Office at (212) 264-9121.

Sincerely,

/s/

Sue Kelly
Associate Regional Administrator
Medicaid and State Operations
New York Regional Office

cc: Tim Perry-Coon, NY Office of Medicaid Management
Mike Fiore, CMS Baltimore

Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

2005 – 2007 Biennium

Appendix C

Medicaid State Plan Amendment 03-011

CPE's

42 CFR 433.51(6)

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(c) *Applicability.* The provisions of this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

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(3) An employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or

(4) A supplier of health care items or services or a supplier to providers of health care items or services.

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Provider-related donation means a donation or other voluntary payment (in

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-011**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $1,812,500
b. FFY 2004 $7,250,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages 2 through 41
Attachment 4.19-b, pages 2, 2-a, 2-b, 2-c, 2-d, 2-e, 4, 4-1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages 2 through 36.
Attachment 4.19-b, pages 2, 2-a, 2-b, 2-c, 4

10. SUBJECT OF AMENDMENT:

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Department of Social and Health Services
Attn: Ann Myers
Medical Assistance Administration
925 Plum St SE MS: 45533
Olympia, WA 98504-5533

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
April 19, 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Dennis G. Smith

22. TITLE: Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

A. INTRODUCTION

The State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. This system, as revised through this amendment, is used to reimburse for admissions on or after January 1, 2001. Revisions to this system are made as necessary through amendments to the State plan.

This plan incorporates revisions that eliminate all disproportionate share and pro-share programs involving intergovernmental transfers. These changes will be effective on July 1, 2005. This plan also incorporates a new payment methodology to be effective July 1, 2005 for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. The new payment methodology incorporates the use of certified public expenditures (CPEs) at each hospital as the basis for claiming federal Medicaid funding for medically necessary patient care.

The hospital rates and payment methods described in this attachment are for the State of Washington Medicaid program. The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care such as skilled nursing and intermediate care, and payment methods for other acute inpatient care such as Long Term Acute Care (LTAC). The rates for these services are lower than those for standard inpatient acute care.

The reimbursement system employs four major methods to determine hospital payment rates: DRG cost-based rates; DRG contract rates; full cost rates (beginning on July 1, 2005); and rates based on hospitals' ratio of costs- to-charges (RCC).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

A. INTRODUCTION (cont.)

Other payment methods used include per member per month (PMPM) graduate medical education (GME) payments, fixed per diem, cost settlement, disproportionate share hospital (DSH), and proportionate share hospital. All are prospective payment methods except the cost settlement payment method used to reimburse critical access hospitals. Newborn screening tests approved through legislative direction are covered services reimbursed by the department and payment adjustments are made when necessary. The DRG,"full cost", and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement provides reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly.

A fixed per diem payment method is used in conjunction with the LTAC program. A cost settlement payment method is used to reimburse hospitals participating in the state's Title XIX Critical Access Hospital (CAH) program. Monthly PMPM GME payments are provided by MAA directly to the University of Washington Medical Center and the Harborview Medical Center for GME related to Healthy Options care.

Contract hospitals participating in the federally waivered Medicaid Hospital Selective Contracting Program are reimbursed for services paid by the DRG payment method based on their negotiated DRG contract rate.

Hospitals not located in contract areas and hospitals located in a contract area that are exempt from selective contracting, are reimbursed for services paid under the DRG payment method using a cost-based DRG rate.

Non-contract hospitals in selective contracting program areas will be paid by MAA for inpatient services only when those services are determined by MAA to be emergency services.

Beginning on July 1, 2005, public hospitals located in the State of Washington, that are not department approved and DOH certified as CAH, are paid the "full cost" of Medicaid and GAUDSH covered services as determined through the Medicare Cost Report, using MAA's Medicaid RCC rate to determine Medicaid cost and the GAUDSH cost.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

A. INTRODUCTION (cont.)

Each public hospital district for its respective non-CAH public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent its costs of the patients' medically necessary care.

Hospitals and services exempt from the DRG payment methods are reimbursed under the RCC, "full cost", cost settlement, or fixed per diem payment method.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing: cost-based DRG rates; "full cost" reimbursement; RCC payment rates; CAH rates; fixed per diem reimbursement; Disproportionate Share Hospital (DSH) reimbursement; upper payment limits (UPL); UPL reimbursement; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, and public notification requirements.

B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan. Allowed charges, where mentioned in this attachment to the state plan, refers to the DSHS covered charges on a claim that are used to determine any kind of reimbursement for medically necessary care.

1. *Accommodation and Ancillary Costs*

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

2. *Case-Mix Index (CMI)*

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

3. *Critical Access Hospital (CAH) Program*

Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program where instate hospitals, that are department approved and DOH Medicare-certified as a CAH, are reimbursed through a cost settlement method.

4. *DSHS or Department*

DSHS or department means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

5. *Diagnosis Related Groups (DRGs)*

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses The All Patient Grouper and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470.

The remainder of the 241 DRGs are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

6. *Emergency Services*

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

7. *HCFA/CMS*

HCFA means the Department of Health and Human Services' former Health Care Financing Administration (HCFA), renamed the Centers for Medicare and Medicaid Services (CMS) in June 2001. CMS, formerly named HCFA, is the federal agency responsible for administering the Medicaid program.

8. *Hospital*

Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

9. *Inpatient Services*

Inpatient services means all services provided directly or indirectly by the hospital subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, related services provided by the hospital within one calendar day of the client's admission as an inpatient.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

10. Long Term Acute Care

Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point at which that determination is made, the mode of care and reimbursement may switch to LTAC under a fixed per diem rate if authorized by DSHS. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

11. *MI/GAU*

MI/GAU, as used in Paragraph F.2 and F.3 below, means the DSHS Limited Casualty Program-Medically Indigent (MI) or General Assistance Unemployable (GAU) services.

12. *RCC*

RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. A reduced RCC is used to calculate MIDSH and GAUDSH payments on RCC paid claims.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

13. *Operating, Medical Education and Capital Costs*

Costs are the Medicare-approved costs as reported on the CMS 2552 and are divided into three components:

Operating costs include all expenses, except capital and medical education, incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, and interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

14. *Uninsured Indigent Patient*

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system.

Charity care and bad debt, as defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and chapter 70.170 RCW "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

Services covered by an insurance policy are not considered an uninsured covered service.

15. *Cost Limit For DSH Payments*

For the purpose of defining cost under the DSH program a ratio of costs-to-charges (RCC) is calculated prospectively using annual CMS 2552 Medicare Cost data. The RCC is applied through a prospective payment method to historical total hospital billed charges to arrive at the hospitals total cost.

16. *DSH One Percent Medicaid Utilization Rate*

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the DSHS disproportionate share programs.

17. *DSH Limit*

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

18. Trauma Centers

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

19. *PII--Psychiatric Indigent Inpatient*

Means DSHS Limited Casualty Program-Psychiatric Indigent Inpatient (PII) services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

20. *"Full Cost" Public Hospital Certified Public Expenditure (CPE) Payment Program*

"Full cost" public hospital certified public expenditure (CPE) payment program means a hospital payment program for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. These hospitals are reimbursed based on the full cost of services as determined through the Medicare Cost Report and MAA's RCC rate. Each of these hospitals certified public expenditures represent the costs of the patients' medically necessary care. Each hospital's Medicaid and GAUDSH claims are paid by the "full cost" payment method, using the Medicaid RCC rate to determine Medicaid cost and the GAUDSH cost.

21. *Peer Groups*

Peer groups mean MAA designated peer groups. MAA's peer grouping has six classifications: Peer group A, which are rural hospitals paid under an RCC methodology; peer group B, which are urban hospitals without medical education programs and which are not in peer group E; peer group C, which are urban hospitals with medical education programs and which are not in peer group E; peer group D, which are specialty hospitals and which are not in peer group E; and peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are certified CAH.

22. *Observation Services*

Observation services means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES

The following section describes general policies governing the reimbursement system. Payment will only be made to the provider for covered services for that portion of a patient admission during which the client is Medicaid eligible.

1. DRG Payments

Except where otherwise specified, DRG exempt hospitals, DRG exempt services and special agreements, payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D.

Any client responsibility (spend-down) and third-party liability, as identified on the billing invoice or otherwise by the department, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission.

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights. To the extent possible, the weights are based on Medical Assistance (Medicaid) claims for hospital fiscal years (HFYs) 1997 and 1998, spanning the period February 1, 1997 through December 31, 1998, and on Version 14.1 of the Health Information Systems (HIS) DRG All Patient Grouper software.

The relative weight calculations are based on Washington Medical Assistance claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care. Each DRG is statistically tested to assure that there is an adequate sample size to ensure that relative weights meet acceptable reliability and validity standards. The relative weights are standardized to an overall case-mix index of 1.0 based on claims used during the recalibration process, but are not standardized to a case-mix index of 1.0 regarding the previous relative weights used.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. DRG High-Cost Outlier Payments

High-cost outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases. To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment and $33,000.

Reimbursement for outlier cases other than cases in children's hospitals (Children's Hospital and Medical Center, Mary Bridge Children's Hospital), and psychiatric DRGs, is the applicable DRG payment amount plus 75 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for outlier cases at the state's two children's hospitals is the applicable DRG payment amount plus 85 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or $450. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC ratio.

5. DRG Long-Stay Day Outlier Payments

Day Outlier payments are included only for long-stay clients, under the age of six, in disproportionate share hospitals and for children under age one in any hospital. (See C.15 Day Outlier payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the RCC method, "full cost" method, CAH method, etc. For RCC and "full cost" payments, the basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. Recipient responsibility (spend-down) and third-party liability, as identified on the billing invoice or otherwise by DSHS, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission.

7. DRG Exempt Hospitals

The following hospitals are exempt from the DRG payment method for Medicaid.

a. Peer Group A Hospitals

As defined in Section D.2.

b. Psychiatric Hospitals

Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Lourdes Counseling Center, West Seattle Psychiatric Hospital, Puget Sound Behavioral Health, the psychiatric unit at Children's Hospital & Medical Center, and all other Medicare-certified and State-approved distinct part psychiatric units doing business with the State of Washington.

c. Rehabilitation Units

Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

In addition, services for clients in the MAA Physical Medicine and Rehabilitation program (PM&R), and who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for PM&R services and placement into the rehabilitation unit.

d. Critical Access Hospital (CAHs)

Department-approved and Medicare designated CAHs receive Medicaid prospective payment based on Departmental Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

e. Managed Health Care

Payments for clients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for contract or non-contract hospitals described in Section D, Section E and/or Section F.

f. Out-of-State Hospitals

Out-of-state hospitals are those facilities located outside of Washington and outside designated border areas as described in Section D. For medically necessary treatment of emergencies that occur while a client is out-of-state, these hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals. For DSHS referrals to out-of-state providers after MAA's Medical Director or designee approved an Exception to Rule for the care:

(1) In absence of a contract, DSHS pays the rate mentioned above.

(2) When DSHS is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. DSHS first negotiates for the rate mentioned above, then for the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

g. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

h. Public Hospitals Located In The State of Washington

Beginning on July 1, 2005, for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and GAUDSH covered services are paid by the "full cost" public hospital certified public expenditure (CPE) payment method. The new payment methodology incorporates the use of certified public expenditures at each hospital as the basis for receiving federal Medicaid funding.

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by DRG payment under the DRG payment method, but not under "full cost", or cost settlement. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC, "full cost", or cost settlement payment method.

b. AIDS-Related Services

AIDS-related inpatient services are exempt from DRG payment methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and other Human Immunodeficiency Virus (HIV) infections.

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

d. Bone Marrow and Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

e. Chemically-Dependent Pregnant Women

Hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method.

f. Long-Term Acute Care Program Services

Long-Term Acute Care (LTAC) services, and other inpatient services provided by LTAC hospitals, are exempt from DRG payment methods. LTAC services covered under the LTAC rate are reimbursed using a fixed per diem rate. Other covered LTAC services are paid using the RCC rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through a vendor rate_adjustment (VRA). Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

g. Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned.

Services provided in DRGs that do not have a Medical Assistance Administration relative weight assigned, that would otherwise be paid using the DRG payment method, are reimbursed using the RCC, "full cost", or cost settlement payment method unless a different payment method has been specified.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

Trauma Center Services

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

Level I, II, and III trauma centers services will be reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

h. Inpatient Pain Center Services

Services in MAA authorized inpatient pain centers are paid using a fixed per diem rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below, the payment to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital; or, the appropriate DRG payment.

If a client is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

The hospital that ultimately discharges the client is reimbursed the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge, to the same hospital that group to the same medical diagnostic category, will be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case. All psychiatric inpatient admissions must be prior authorized and are considered distinct admissions, regardless of the number of days occurring between admissions.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

11. Administrative Days Policy

Administrative days are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1. For DRG exempt cases, administrative days are identified during the length of stay review process.

12. Inpatient vs. Outpatient Stay Policy

Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services. On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.

An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

13. Medicare Related Policies

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider cannot exceed DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

In cases where the Medicare crossover client's Part A benefits, including lifetime reserve days, are exhausted, and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described in C.3. above.

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the LTAC program. A fixed per diem is also used to pay for authorized inpatient pain center services.

These fixed per diem rates are established through identification of historical claims costs for the respective services provided. Predetermined Vendor rate adjustments are made annually if rates are not rebased. For SFY 04 the vendor rate adjustment is 0.0%.

15. Third-Party Liability Policy

For DRG cases involving third-party liability (TPL), a hospital will be reimbursed the lesser of the DRG billed amount minus the TPL payment and other appropriate deductible amounts, or the applicable DRG allowed amount (basic payment) for the case minus the TPL payment and other appropriate deductible amounts. For RCC cases involving TPL, a hospital will be reimbursed the RCC allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For CAH cases involving TPL, a hospital will be reimbursed the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For "full cost" cases involving TPL, a hospital will be reimbursed the federal match portion of the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

16. Day Outliers:

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one.

A hospital is eligible for the day outlier payment if it meets the following:

a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG.

c. The charge for the patient stay is under $33,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

17. Trauma Care Enhancement

The Level I, II, and III trauma center enhanced payment is based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont.)

17. Trauma Care Enhancement (cont.)

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

18. Adjustment for New Newborn Screening Tests

A payment adjustment is made for new legislatively approved and funded newborn screening tests not paid through other rates.

D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education). The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form CMS 2552) for their fiscal year (FY) 1998. Cost data that was desk reviewed and/or field audited by the Medicare intermediary before the end of the rebasing process was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) are extracted from the CMS 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

1. Base Period Cost and Claims Data (cont.)

Nine categories are used to assign hospitals' accommodation costs and days of care, and 29 categories are used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1998 period are extracted from the state's Medicaid Management Information System (MMIS).
Department of Health Composite Hospital Abstract Reporting System (CHARS) claims representative of services covered and provided by Healthy Options managed care plans are also extracted. Line item charges from claims are assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data are also used to compute hospitals' FY 1998 case-mix index.

2. Peer Groups & Caps

MAA's peer grouping has six classifications: Peer group A, which are non-CAH, rural hospitals which are not in peer group E and for Medicaid claims are paid under an RCC methodology; peer group B, which are non-CAH urban hospitals without medical education programs which are not in peer group E; peer group C, which are urban hospitals with medical education programs which are not in peer group E; peer group D, which are specialty hospitals which are not in peer group E; peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are department approved and DOH certified as CAH.

For the DRG payment method, indirect medical education costs are removed from operating and capital costs, and direct medical education costs are added.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

2. Peer Groups & Caps (cont.)

Peer group caps for peer groups B and C are established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceed the 70th percentile of the peer group are reset at the 70th percentile cap. The hospitals in peer group D are exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons. The hospitals in peer group E are exempted from the peer group caps because they are paid "full cost" of services as determined through the Medicare Cost Report using the Medicaid RCC rates to determine cost. The hospitals in peer group F are also exempted from the peer group caps.

Changes in peer group status as a result of MAA approval or recommendation are recognized. However, in cases where post-rate calculation corrections or changes in individual hospital's base year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus have an impact on the peer-group cap, the cap is updated only if it results in a 5.0 percent or greater change in total Medicaid payment levels.

3. Conversion Factor Adjustments

Indirect medical education costs are added back into costs before application of any inflation adjustment. A 0.008219 percent per day inflation adjustment (3.0 percent divided by 365 days) is used for hospitals that have their fiscal year ending before December 31, 1998. A 9.1086 percent inflation adjustment is used for the period from January 1, 1999 to October 31, 2001.

Annually all cost-based conversion factors are adjusted by a predetermined vendor rate adjustment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that are not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies are established to estimate these costs. Per diem proxies are developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital is calculated based on the Medicaid cases for each hospital during its FY 1998 cost report period.

6. Indirect Medical Education Costs

An indirect medical education cost is established for operating and capital components in order to remove indirect medical education related costs from the peer group caps.

To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds is multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio is multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component.

The indirect medical cost is trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

7. Rate Calculation Methodology

Step 1: For each hospital, the base period cost data are used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories. These costs are divided by total hospital days per category to arrive at a per day accommodation cost.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

7. Rate Calculation Methodology (cont.)

The accommodation costs per day are multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data are also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs are divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

These ratios are multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs are combined to derive the operating, capital and direct medical education's components. These components are then divided by the number of Medicaid cases to arrive at an average cost per admission.

Step 4: The three components' average cost per admission are next adjusted to a common fiscal year end (December 31, 1998) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital is removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost is set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in are next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1999 through October 31, 2001. The outlier set-aside factor is then subtracted to arrive at the hospital's January 1, 2001 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

Those in-state and border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

8. Border Area Hospitals Rate Methodology

Border area hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River and Sandpoint.

These hospitals' cost-based rates are based on their FY 1998 Cost Reports and FY 1998 claims, if available.

Those border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to January 1, 2001. A change in ownership does not constitute the creation of a new hospital. New hospitals' cost-based rates are based on the peer group average final conversion factor for their hospital peer group, less the outlier set aside factor.

10. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

E. RCC RATE METHOD

The RCC payment method is used to reimburse Peer Group A hospitals for their costs and other hospitals for certain DRG exempt services as described in Section C.8. This method is not used for hospitals reimbursed using the "full cost" CPE method except that the Medicaid RCC rates are used to determine "full cost" for those hospitals.

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E. RCC RATE METHOD (cont)

The RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and border area hospitals which the State determines have insufficient data or Medicaid claims to accurately calculated an RCC ratio, is also the average of RCC ratios for in-state hospitals. Hospital's RCC ratios are updated annually with the submittal of new CMS 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

F. "FULL COST" PUBLIC HOSPITAL CERTIFIED PUBLIC EXPENDITURE (CPE) PAYMENT METHODOLOGY (effective July 1, 2005)

The public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, will be reimbursed using the "full cost" payment method using their respective Medicaid RCC rate to determine cost for covered medically necessary services. The payment method incorporates the use of certified public expenditures (CPEs) at each hospital as the basis for claiming federal Medicaid funding for the cost of medically necessary patient care. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by DSHS is deducted from the allowed amount (basic payment) to determine the actual payment for that admission. The costs as determined above will be certified as actual expenditures by the hospital and the DSHS claim will be the allowed federal match on the amount of the related certified public expenditures. DSHS will verify that the expenditures certified were actually incurred.

G. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program, a hospital must meet the Medicaid one-percent utilization to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

All the DSH payments will not exceed the State's DSH allotment. To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

Cost is established through prospective payment methods and is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.

DSHS will not exceed the DSH statewide allotment nor allow a hospital to exceed the DSH limit. The following clarification of the process explains precautionary procedures.

All the DSHS DSH programs' payments are prospective payments, and these programs are: LIDSH, MIDSH, GAUDSH, SRHAPDSH, SRHIAAPDSH, NRHIAAPDSH, THAPDSH (ends June 30, 2005), STHFPDSH (ends June 30, 2005), CTHFPDSH (ends June 30, 2005) and PHDDSH.

DSH programs for which payments are fixed represent 97 percent of DSHS' disproportionate share payments to hospitals. The other two DSH programs, MIDSH and GAUDSH, are paid on a by-claims basis. To adjust for these unknowns in the MIDSH and GAUDSH, MAA uses claims data and estimates what expected expenditures would be paid during the current state fiscal year. This estimate then becomes a part of the hospital's cost limit.

The Medical Assistance Administration (MAA) will monitor payments monthly. Each month, MAA will receive an MI Summary Report and GAU Summary Report from the Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the MIDSH and GAUDSH programs.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

Each month MAA will also receive the DSHS Allotment/Expenditure Transaction Register identifying the remaining DSH program expenditures. The figures in these reports will be accumulated monthly to determine that hospitals have not exceeded the DSH limit.

If a hospital reaches its DSH limit, payments will be stopped. The Department of Social and Health Services (DSHS) will determine the extent to which and how each DSH program is funded. Any specific guidance that may be provided by the State legislature will be followed by DSHS.

If a hospital exceeds its DSH limit, DSHS will recoup the DSH payments in the following program order: PHDDSH, THAPDSH (ends June 30, 2005), CTHFPDSH (ends June 30, 2005), STHFPDSH (ends June 30, 2005), SRHAPDSH, NRHIAAPDSH, SRHIAAPDSH, GAUDSH, and LIDSH. For example, if a hospital were receiving payments from all DSH programs, the overpayment adjustment would be made in PHDDSH to the fullest extent possible before adjusting THAPDSH payments. If the DSH state-wide allotment is exceeded, DSHS will similarly make appropriate adjustments in the program order shown above.

1. Low-Income Disproportionate Share Hospital (LIDSH) Payment

Hospitals shall be deemed eligible for a LIDSH payment adjustment if:

a. The hospital's Medicaid inpatient utilization rate (as defined in Section 1923(b)(2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or,

b. The hospital's low-income utilization rate (as defined in Section 1923 (b)(3)) exceeds 25 percent.

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals deemed eligible under the above criteria shall receive disproportionate share payment amounts that in total will equal the funding set by the State's appropriations act for LIDSH. The process of apportioning payments to individual hospitals is as follows:

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

1. LIDSH Payments (cont.)

A single base payment is selected that distributes the total LIDSH appropriation. For each hospital, the base payment is multiplied by the hospital's low income utilization factor standardized to one, by the hospital's most recent Fiscal Year case mix index by the hospital's subsequent year's estimated admissions of Title XIX eligibles. Results for all hospitals are summed and compared to the appropriated amount.

If the sum differs from the appropriated amount, a new base payment figure is selected. The selection of base payment figures continues until the sum of the calculated payment equals the appropriated amount. The appropriation amount may vary from year to year. Each hospital's disproportionate share payment is made periodically.

2. Medically Indigent Disproportionate Share Hospital (MIDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a MIDSH payment if:

a. The hospital is an in-state or border area hospital; and,

b. The hospital provides services to low-income, Medically Indigent (MI) patients. MI persons are low-income individuals who are not eligible for any health care coverage and who are encountering an emergency medical condition; and,

c. The hospital has a low-income utilization rate of one percent or more; and,

d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Effective through June 30, 2005, hospitals shall be deemed eligible for a MIDSH payment of claims for dates of service prior to July 1, 2003 if the payment is for services to MI patients provided prior to July 1, 2003.

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G. DSH PAYMENTS (cont.)

2. MIDSH Payments (cont.)

Hospitals shall be deemed eligible for a MIDSH payment of claims for services provided on or after July 1, 2003, only for Psychiatric Indigent Inpatient (PII) services and when requirements a. through d., above, are met. PII services are for low-income individuals who are not eligible for any health care coverage and require psychiatric medical care.

Hospitals qualifying for MIDSH payments will receive a periodic per claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. The equivalency factor ensures that MIDSH payments will equal the State's estimated MIDSH appropriation level.

Effective for admissions on or after July 1, 1994, the payment is reduced further by multiplying it by 97 percent. The resulting payment is directly related to the hospital's volume of services provided to low-income MI patients. This payment reduction adjustment is applied to the MIDSH methodology established and in effect as of September 30, 1991 in accordance with Section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991." The emergency medical expense requirement (EMER) deductible is not part of the MIDSH actual payment and will be deducted pre or post pay from the department's MI allowed amount (basic payment) to the hospital.

3. General Assistance Unemployable Disproportionate Share Hospital (GAUDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a GAUDSH payment if:

a. The hospital is an in-state or border area hospital; and,

b. The hospital provides services to low-income, General Assistance Unemployable (GAU) patients. GAU persons are low-income individuals who are not eligible for any health coverage and who are encountering a medical condition; and,

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G. DSH PAYMENTS (cont.)

3. GAUDSH Payments (cont.)

c. The hospital has a low-income utilization rate of one percent or more; and,

d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for GAUDSH payments will receive a periodic per claim payment. For all hospitals, except public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, the payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCC to determine cost for the medically necessary care. The equivalency factor insures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

4. Small Rural Hospital Assistance Program Disproportionate Share Hospital (SRHAPDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a SRHAPDSH payment if:

a. The hospital is an in-state (Washington) hospital; and

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard to be increased by two percent each subsequent SFY; and

d. The hospital qualifies under Section 1923(d) of the Social Security Act.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

4. SHRHAPDSH Payments (cont.)

Hospitals qualifying for SRHAPDSH payments started earning payments under this plan July 1, 1994, from a legislatively appropriated pool. The apportionment formula is based on each SRHAPDSH hospital's Medicaid and other low-income reimbursement during the most current state fiscal year less any low-income disproportionate share payments.

To determine each hospital's percentage of Medicaid payments, the sum of individual hospital payments is divided by the total Medicaid payments made to all SRHAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of payments, hospitals with a low profitability margin will have their total payments set at 110% of actual payments. MAA will calculate each hospital's net operating margin based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines.

Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them. Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRHAPDSH pool. The payments are made periodically. SRHAPDSH payments are subject to federal regulation and payment limits.

5. Small Rural Hospital Indigent Adult Assistance Program Disproportionate Share Hospital (SRHIAAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a SRHIAAPDSH payment if:

a. The hospital is an in-state (Washington) hospital; and

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G. DSH PAYMENTS (cont.)

5. SHRHIAAPDSH Payments (cont.)

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard increased by two percent each subsequent SFY; and

d. The hospital qualifies under Section 1923(d) of the Social Security Act; and

e. The hospital provided services to low-income, Medically Indigent (MI) patients during the calculation base year. MI persons are low-income individuals who are not eligible for any health care coverage and who are encountering emergency medical conditions.

Hospitals qualifying for SRHIAAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. The apportionment formula is based on each SRHIAAPDSH hospital's calculated costs for qualifying MI patients during the most currently available state fiscal year.

To determine each hospital's percentage of MI payments, the sum of individual hospital calculated MI costs is divided by the total MI calculated costs of all SRHIAAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of calculated MI costs, hospitals with a low profitability margin will have their total calculated MI costs adjusted to 110% of calculated MI costs. MAA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Payments for SRHIAAPDSH will be made in conjunction with payments for SRHAPDSH.

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G. DSH PAYMENTS (cont.)

5. SHRHIAAPDSH Payments (cont.)

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRHIAAPDSH pool. The payments are made periodically. SRHIAAPDSH payments are subject to federal regulation and payment limits.

6. Teaching Hospital Assistance Program Disproportionate Share Hospital (THAPDSH) Payment (Program ends June 30, 2005)

Effective July 1, 1994, teaching hospitals shall be deemed eligible for a THAPDSH payment if they meet the following eligibility standards:

a. The hospital must be a Washington State university hospital; and

b. The hospital must have at least two obstetricians, with staff privileges at the hospital, who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services. This standard does not apply to hospitals which do not offer non-emergency obstetric services to the general population; and

c. The hospital must have a Medicaid low-income utilization of 20 percent or above.

Hospitals qualifying for THAPDSH payments started receiving payments under this plan July 1, 1994. THAPDSH payments will be made from a legislatively appropriated pool and are equally divided between THAPDSH qualified hospitals.

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G. DSH PAYMENTS (cont.)

7. State Teaching Hospital Financing Program Disproportionate Share Hospital (STHFPDSH) Payment (Program ends June 30, 2005)

Effective June 15, 1997, hospitals shall be deemed eligible for a STHFPDSH payment if:

a. The hospital provides at least 20 percent of its services to low-income patients; and,

b. The hospital is a Washington state-owned university hospital (border area hospitals are excluded); and,

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

d. The hospital qualifies under section 1923(d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payment to state and county teaching hospitals.

The STHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

8. County Teaching Hospital Financing Program Disproportionate Share Hospital (CTHFPDSH) Payment (Program ends June 30, 2005)

Effective July 1, 1993, hospitals shall be deemed eligible for a CTHFPDSH payment if:

a. The hospital provides at least 25 percent of its services to low-income patients;

b. The hospital is a county hospital in Washington State (border area hospitals are excluded);

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

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G. DSH PAYMENTS (cont)

8. CTHFPDSH Payments (cont.)

d. The hospital qualifies under section 1923 (d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payments to state and county teaching hospitals.

The CTHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

9. Public Hospital District Disproportionate Share Hospital (PHDDSH) Payment (Program ends June 30, 2005)

Effective June 1, 1995, hospitals shall be deemed eligible for a PHDDSH payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a Public District Hospital in Washington State (as of June 15, 1997, border area public hospitals are included);

c. The hospital qualifies under section 1923 (d) of the Social Security Act.

d. The hospital is not department approved and DOH certified as CAH under Washington State Law and federal Medicare rules.

Public hospital districts are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

9. PHDDSH Payments (cont.)

Hospitals that apply and are deemed eligible under the above criteria shall receive a disproportionate share payment for hospital services during the State's fiscal year that in total will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines. Each hospital will receive a payment based on the factors specified in Section 1923(g) of the Social Security Act. Payments in the program shall be based on the relative amount of uncompensated care incurred by the hospital during the year preceding payment. Hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount. The pool for PHDDSH payments is legislatively appropriated.

The PHDDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

10. Non-Rural Hospital Indigent Adult Assistance Program Disproportionate Share Hospital (NRHIAAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a NRHIAAPDSH payment if:

a. The hospital provides at least one percent of its services to low-income patients in Washington state; and

b. The hospital does not qualify as a Small Rural Hospital as defined in section G.4.a and G.4.c. of this plan; and

c. The hospital qualifies under Section 1923(d) of the Social Security Act.

Hospitals qualifying for NRHIAAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. The apportionment formula is based on each NRHIAAPDSH hospital's calculated costs for patients in the Medically Indigent program during the most currently available state fiscal year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

10. NRHIAAPDSH Payments (cont.)

To determine each hospital's percentage of payments for patients in the Medically Indigent program, the sum of individual hospital calculated costs is divided by the total calculated costs for patients in the Medically Indigent program of all NRHIAAPDSH hospitals. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of costs for patients in the Medically Indigent program, hospitals with a low profitability margin will have their total calculated MI costs adjusted to 110% of calculated MI costs. MAA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the NRHIAAPDSH pool. The payments are made periodically. NRHIAAPDSH payments are subject to federal regulation and payment limits.

11. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals shall be deemed eligible for a PHDSH payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a public hospital in Washington State (includes the Harborview Medical Center, the University of Washington Medical Center, and public hospitals located in the State of Washington that are owned by public hospital districts;

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

11. PHDSH Payments (cont.)

c. The hospital qualifies under section 1923 (d) of the Social Security Act.

d. The hospital is not department-approved and DOH certified as CAH under Washington State Law and federal Medicare rules.

Harborview is a county-owned, state-operated hospital. The University of Washington Medical Center is a state-owned and operated hospital. Public hospital districts located in the State of Washington are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Those public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Hospitals that apply and are deemed eligible under the above criteria shall receive a disproportionate share payment for hospital services during the State's fiscal year that in total will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines. Payments in the program shall be based on the amount of uncompensated care incurred by the hospital during the year preceding payment.

The DSH payment will be based on expenditures certified by the hospital in an amount as specified in the preceding paragraph.

G. CUSTOMARY CHARGE PAYMENT LIMITS

As required by 42 CFR 447.271, total annual Medicaid payments to each hospital for inpatient hospital services to Medicaid recipients shall not exceed the hospital's customary charges to the general public. The state may recoup amounts of total Medicaid payments in excess of such charges. This customary charge limit does not apply to CAH cost settlement.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

H. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedure

A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the DSHS (the Medical Assistance Administration) except that no administrative appeals may be filed challenging the method described herein.

The grounds for rate adjustments include, but are not limited to, errors or omissions in the data used to establish rates, changes in capital costs due to licensing or certification requirements, and peer group change recommended by the Medical Assistance Administration.

Additional documentation, as specified by DSHS, may be required in order to complete the appeal review. DSHS (the Medical Assistance Administration) may have an audit and/or desk review conducted if necessary to complete the appeal review. A hospital may appeal its rates by submitting a written notice of appeal to the Office of Hospital and Managed Care Rates, Medical Assistance Administration.

Unless the written rate notification specifies otherwise, a hospital rate appeal requesting retroactive rate adjustments must be filed within 60 days after being notified of an action or determination the hospital wishes to challenge. The notification date of an action or determination is the date of the written rate notification letter.

A hospital rate adjustment appeal, filed after the 60-day period described in this subsection shall not be considered for retroactive adjustments.

When an appeal is made, all aspects of this rate may be reviewed by DSHS.

Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal filed within 60 days after the written rate notification letter that the hospital is challenging shall be effective retroactively to the effective date of the rate change as specified in the notification letter.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

H. ADMINISTRATIVE POLICIES (cont.)

Increases in rates resulting from a rate appeal filed after the 60-day period or exception period shall be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases shall be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the MAA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete their official annual Medicare cost report (CMS 2552) according to the applicable Medicare statutes, regulations, and instructions and submit a copy of their official annual Medicare cost report (CMS 2552), including Medicaid related data, to MAA. This submittal to MAA should be an identical copy of the official Medicare cost report (CMS 2552) submission made by the hospital provider to the Medicare fiscal intermediary for the hospital's fiscal year.

The Medicare cost report (CMS 2552) should be submitted to MAA within one hundred fifty days from the end of the hospital's fiscal year, or if the hospital provider's contract with DSHS is terminated, within one hundred and fifty calendar days of the effective termination date.

The hospital may request up to a thirty-day extension of the deadline for submitting the Medicare cost report (CMS 2552) to MAA. The extension request must be in writing and be received by MAA at least ten calendar days prior to MAA's established due date for receiving the report. The extension request must clearly explain the circumstances leading to the reporting delay. MAA may grant the extension request if MAA determines the circumstances leading to the reporting delay are valid.

In cases where Medicare has granted a hospital provider a delay in submitting its Medicare cost report (CMS 2552) to the Medicare fiscal intermediary, MAA may grant an equivalent reporting delay.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

H. ADMINISTRATIVE POLICIES (cont.)

This reporting delay may be granted when the hospital provider provides MAA a copy of the written notice from Medicare that granted the delay in Medicare cost report (CMS 2552) reporting to the Medicare fiscal intermediary. The hospital provider should submit a written extension request to MAA, along with the copy of the written notice from Medicare, at least ten calendar days prior to MAA's established due date for receiving the Medicare cost report (CMS 2552).

If a hospital provider submits to MAA a copy of an improperly completed Medicare cost report (CMS 2552) or a copy that is not the official Medicare cost report (CMS 2552) that has already been submitted for the fiscal year to the Medicare fiscal intermediary, or if the cost report is received after MAA's established due date or approved extension date, MAA may withhold all or part of the payments due the hospital until MAA receives a copy of a properly completed Medicare cost report (CMS 2552) that has been submitted for that fiscal year to the Medicare fiscal intermediary.

In addition, hospitals are required to submit other financial information as requested by MAA to establish rates.

3. Financial Audit Requirements

Cost report data used for rate setting will be periodically audited.

In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS will rebase the Medicaid payment system on a periodic basis using each hospital's Medicare cost report (CMS 2552) for its fiscal year ending during the base year selected for the rebasing.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

I. UPPER PAYMENT LIMIT PAYMENTS FOR PUBLIC HOSPITALS OWNED BY PUBLIC HOSPITAL DISTRICTS, AND STATE AND COUNTY TEACHING HOSPITALS, THAT ARE LOCATED IN THE STATE OF WASHINGTON

1. An upper payment limit (UPL) pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid patient services. Eligible providers are King County-owned or Washington State-operated teaching hospitals, and public hospitals owned by public hospital districts, located in the State of Washington that are not department approved and DOH certified as CAH, as designated each year by the department.

2. The supplemental payments made to eligible providers are subject to prior federal approval for obtaining federal matching funds for the supplemental payments. The supplemental funds are subject to the federal Medicare upper payment limit for hospital payments. The Medicare upper limit analysis will be performed prior to making the supplemental payments.

3. The Medicare Upper Payment Limit (UPL) payment for each payment year is determined as follows:

   The cumulative difference between the UPL and Title XIX payments and third party liability payments for all eligible hospitals during the most recent Federal Fiscal year becomes the total UPL payment that will be distributed during the payment year. The source of the charge and payment data is the State's Medicaid Management Information System (MMIS) for the base year. Only charges and payments for inpatient hospital services are included in the computation, and the base year determined amount is not inflated to the payment year.

4. Payments will be distributed to the eligible hospitals based on eligibility under the UPL, in proportion to the dollars resulting from the difference between Hospital Allowed Charges and Title XIX payments, including third party. The supplemental payment is at least annually during each federal fiscal year.

Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

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Appendix D

Applicable Washington Administrative Code (WAC) Sections

CR-102 DRAFT
388-550-3300

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes the department groups hospitals into peer groups and establishes cost caps for each peer group. The department sets hospital reimbursement rates at levels that recognize the costs of reasonable, efficient, and effective providers.

(2) The six medical assistance administration (MAA) hospital peer groups are:

(a) Group A, rural hospitals;

(b) Group B, urban hospitals without medical education programs;

(c) Group C, urban hospitals with medical education program;

(d) Group D, specialty hospitals or other hospitals not easily assignable to the other three groups;

(e) Group E, public hospitals participating in the full cost public hospital certified public expenditure (CPE) program; and

(f) Group F, critical access hospitals.

(3) MAA uses a cost cap at the seventieth percentile for a peer group.

(a) MAA caps at the seventieth percentile the costs of hospitals in peer groups B and C whose costs exceed the seventieth percentile for their peer group.

(b) MAA exempts peer group A hospitals from the cost cap because they are paid under the ratio of costs-to-charges methodology for Medicaid claims.

(c) MAA exempts peer group D hospitals from the cost cap because they are specialty hospitals without a common peer group on which to base comparisons.

(d) MAA exempts peer group E hospitals from the cost cap because they are paid under the ratio of costs-to-charges (RCC) methodology for Medicaid and GAU inpatient claims.

(e) MAA exempts peer group F hospitals from the cost cap because they are paid under the departmental weighted costs-to-charges methodology for Medicaid claims.

(4) MAA calculates a peer group's cost cap based on the hospitals' base period costs after subtracting:

(a) Indirect medical education costs, in accordance with WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5) MAA uses the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor. After the peer group cost cap is calculated, MAA adds back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) In its rate setting process for peer groups A, B, and F, MAA recognizes changes in peer group status and considers DOH's approval or recommendation. In cases where corrections or changes in individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, MAA updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will result in a five percent or greater change in the seventieth percentile of costs calculated for its peer group.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3300, filed 7/31/01, effective 8/31/01 Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200,[74.09.]500 , [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

CR-102 DRAFT
WAC 388-550-4300

WAC 388-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are reimbursed by the RCC payment method described in WAC 388-550-4500.

(2) Subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to Medicaid-eligible clients:

(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii)

Other state-only administered programs.

(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.

(c) Peer group F hospitals (critical access hospitals).

(d) Rehabilitation units when the services are provided in medical assistance administration (MAA)-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

MAA uses the same criteria as the Medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Exception: Inpatient rehabilitation services provided to clients eligible under the following programs are covered and reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii)

Other state-only administered programs.

(e) Out-of-state hospitals excluding hospitals located in designated border areas as described in WAC 388-501-0175. Inpatient services provided to clients eligible under the following programs are not covered or reimbursed by the department:

(i) General assistance programs; and

(ii)

Other state-only administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) A negotiated per diem rate; or

(ii) DRG.

(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with Medicare certified distinct psychiatric units. The department uses the same criteria as the Medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(A) General assistance programs; and

(B)

Other state-only administered programs.

(ii) If the department determines that the psychiatric services provided to clients eligible under the programs listed in subsection (2)(g)(i) of this section qualify for a special exemption, the services may be reimbursed by using the ratio of costs-to-charges (RCC) payment method.

(iii) Regional support networks (RSNs) that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through an RSN are paid through the department's MMIS payment system.

(3) The department limits inpatient hospital stays that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, "*Length of Stay by Diagnosis and Operation, Western Region*," unless the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to eligible clients, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three-and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

CR-102 DRAFT
NEW SECTION
388-550-4650

NEW SECTION

WAC 388-550-4650 "Full cost" public hospital certified public expenditure (CPE) payment program.

(1) The medical assistance administration's (MAA's) "full cost" public hospital certified public expenditure (CPE) payment program is a public hospital program that pays eligible hospitals the same amount as the Medicaid federal match portion of the "full cost" of covered medically necessary services. MAA uses the ratio of costs-to-charges methodology described in WAC 388-550-4500 to determine "full cost."

(2) Only the following facilities are reimbursed through the "full cost" public hospital CPE payment program:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; and
(ii) Not department-approved or department of health (DOH)-certified as critical access hospital;

(b) Harborview Medical Center; and

(c) University of Washington Medical Center.

(3) Payments made under the CPE payment program are limited to inpatient hospital services provided to clients eligible under the Medicaid and general assistance-unemployable (GA-U) fee-for-service programs.

(4) Each hospital described in subsection (2) of this section is responsible to provide certified public expenditures as the required state match for claiming federal Medicaid funds. Certified public expenditures cannot include federal funds or money used to match federal funds.

(5) Payments made by MAA under the CPE payment program equal the hospital's RCC rate times allowable charges times the state's Medicaid federal match percentage.

(6) Client responsibility and third party liability as identified on the hospital claim or by MAA are deducted from the basic payment to determine MAA's actual payment for that admission.

CR-102 DRAFT
388-550-4800

WAC 388-550-4800 Hospital payment methods--State administered programs. (1) Except as provided in subsection (2) of this section, the medical assistance administration (MAA) uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to reimburse hospitals at reduced rates for covered services provided to a client not eligible under any Medicaid program and:

(a)

Who qualifies for the general assistance unemployable (GAU) program; or

(b) Is involuntarily detained under the Involuntary Treatment Act (ITA)

(2) MAA exempts the following services from the state-administered programs' payment methods and/or reduced rates:

(a) Detoxification services when the services are provided under an MAA-assigned provider number starting with "thirty-six." (MAA reimburses these services using the Title XIX Medicaid RCC payment method.)

(b) Program services provided by MAA-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (MAA reimburses these services through cost settlement as described in WAC 388-550-2598.)

(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (MAA reimburses these services through the "full cost" public hospital certified public expenditure (CPE) program (see WAC 388-550-4650).

(3) MAA determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX Medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX Medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) MAA determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate = current Title XIX Medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:

State-administered programs' DRG CF = current Title XIX Medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) MAA determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative weight
(See subsection (6) of this section for how MAA determines payments for state-administered program claims that qualify as DRG high-cost outliers.)

(6) For state-administered program claims that qualify as DRG high-cost outliers, MAA determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

High-cost Outlier Calculations for Qualifying Claims
State-administered Programs
(for admission dates January 1, 2001 and after)

In-state Children's Hospitals	Allowed charges	(-)	> of $33,000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1(-) Ratable	(x)	85%	(=)	Outlier Add-on Amount	(+)	*DRG Allowe Amoun
Psychiatric DRGs 424-432	Allowed charges	(-)	> of $33,000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1(-) Ratable	(x)	100%	(=)	Outlier Add-on Amount	(+)	*DRG Allowe Amoun
All other qualifying claims	Allowed charges	(-)	> of $33,000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1(-) Ratable	(x)	60%	(=)	Outlier Add-on Amount	(+)	*DRG Allowe Amoun

*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8_) MAA determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9)To calculate a hospital's ratable that is applied to both the Title XIX Medicaid RCC rate and the Title XIX Medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, MAA:

(a) Adds the hospital's Medicaid revenue (Medicaid revenue as reported by department of health (DOH) includes all Medicaid revenue and all other medical assistance revenue) and Medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 Medicare cost report received by MAA at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific Medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific Medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital Medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an instate-average ratable and an instate-average ratable factor used for new hospitals with no prior year history.

(10) MAA updates each hospital's ratable annually on August 1.

(11) MAA:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX Medicaid DRG CBCF x (one minus the prior ratable)

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-19-113, § 388-550-4800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-4800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652. 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200,[74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

CR-102 DRAFT
388-550-4900

WAC 388-550-4900 Disproportionate share payments. As required by section 1902 (a)(13)(A) of the Social Security Act, the medical assistance administration (MAA) gives consideration to hospitals that serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals per legislative direction and established prospective payment methods. MAA considers this adjustment a disproportionate share hospital (DSH) payment.

(1) To qualify for a DSH payment for each state fiscal year (SFY), an instate or border area hospital provider must submit to MAA, the hospital's completed and final DSH application by the due date specified in that year's application letter. The application due date will not be less than sixty days after MAA makes the application available.

(2) A hospital is a disproportionate share hospital eligible for the low-income disproportionate share hospital (LIDSH) program for a specific SFY if the hospital submits a DSH application for that specific year in compliance with subsection (1) and if both the following apply:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or its low-income utilization rate (LIUR) exceeds twenty-five percent; and

(b) At least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services to eligible individuals at the hospital. For the purpose of establishing DSH eligibility, "obstetric services" is defined as routine nonemergency delivery of babies. This requirement for two obstetricians with staff privileges does not apply to a hospital:

(i) That provides inpatient services predominantly to individuals under eighteen years of age; or

(ii) That did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) MAA may consider a hospital a disproportionate share hospital for programs other than the LIDSH program if the hospital submits a DSH application for the specific year and meets the following criteria for the year specified in the application:

(a) The hospital has a MIPUR of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(b) of this section.

(5) MAA administers the low-income disproportionate share (LIDSH) program and may administer any of the following DSH programs:

(a)

General assistance-unemployable disproportionate share hospital (GAUDSH);

(b) Small rural hospital assistance program disproportionate share hospital (SRHAPDSH);

(c) Small rural hospital indigent adult assistance program disproportionate share hospital (SRHIAAPDSH);

(d) Nonrural hospital indigent adult assistance program disproportionate share hospital (NRHIAAPDSH); and

(e) Public hospital disproportionate share hospital (PHDSH).

(6) MAA allows a hospital to receive any one or all of the DSH payment adjustments discussed in subsection (5) of this section when the hospital:

(a) Meets the requirements in subsection (4) of this section; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through388-550-5400 .

(7) MAA ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:

(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;

(b) Less the amount paid by the state under the non-DSH payment provision of the state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients;

(d) Less any cash payments made by uninsured clients; and

(e) Plus any adjustments required and/or authorized by federal regulation.

(8) MAA's total annual DSH payments must not exceed the state's DSH allotment for the federal fiscal year.

If the MAA statewide allotment is exceeded, MAA may adjust future DSH payments to each hospital to compensate for the amount overpaid. Adjustments will be made in the following program order:

(a)

SRHAPDSH;

(b) NRHIAAPDSH;

(c) SRHIAAPDSH;

(d) GAUDSH;

(e) LIDSH; and

(f) PHDSH.

[Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

CR-102 DRAFT
388-550-5400

WAC 388-550-5400 Payment method—PHDSH.

(1) The medical assistance administration's (MAA's) public hospital disproportionate share hospital (PHDSH) program is a public hospital program for:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; and
(ii) Not department-approved or department of health (DOH)-certified as critical access hospital;

(b) Harborview Medical Center; and

(c) University of Washington Medical Center.

(2) MAA pays hospitals eligible under this program a payment equal to the hospital's individual disproportionate share hospital (DSH) payment limit calculated according to WAC 388-550-4900. The resulting amount is multiplied by the federal matching assistance percentage in effect for Washington State at the time of the payment. This amount is sent to the hospital.

(3) Hospitals receiving payment in this DSH program must certify that funds have been spent on uncompensated care at the hospital equal to or in excess of the payment amount before applying the federal matching assistance percentage. Certified funds cannot include federal funds or money used to match federal funds. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5400, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

2005 – 2007 Biennium

Appendix E

Sample Certification Letter for Public Expenditures

State of Washington
Department of Social and Health Services

April 15, 2005

Hospital Chief Financial Officer
Hospital
Address

RE: Certification of Public Funds for Medicaid Expenditures

Dear

As you know, your hospital is included in the Certified Public Expenditures (CPE) Program, authorized by the 2005 – 2007 Biennial State Budget (ESSB 6090) and by the federal Centers for Medicare and Medicaid Services.

In the CPE program, hospitals are reimbursed for Medicaid inpatient claims and for uncompensated care costs at an estimated full cost amount, adjusted to the federal portion of full cost. This methodology calculates payments at the estimated full cost and multiplies the payment amount by the Federal Matching Assistance Percentage (50% for Washington). The resulting amount is the payment made by the State to the hospital. The remainder of the payment is funded by public funds available to the certifying hospital.

This letter provides for the annual certification of public expenditures for the year ended June 30, 2006. Certification is required by the federal regulations governing certified public expenditures.

Separate methods are used to calculate inpatient hospital and disproportionate share hospital (DSH) payments for this hospital. The amount of CPE to be certified as calculated by the State is shown below.

Amount of CPE

- Inpatient Medicaid Claims Paid – based on a prospective RCC methodology, RCC calculated with base year costs.
    - Total charges on claims paid: $xxx
    - Ratio of Cost to Charges for your hospital: xxx
    - Resulting certification amount: $xxx

- Disproportionate Share Hospital Payments – based on a prospective calculation of the hospital's facility DSH limit (total cost of serving uninsured patients and shortfall of Medicaid funding for outpatient and managed care claims).
    - Total DSH facility payment limit: $xxx

By signing below, the Chief Financial Officer certifies that the certification amounts listed above represent an estimate of the cost of services that were provided by the hospital during the year ending June 30, 2006, based on the cost-to-charge ratio incurred by the hospital in a previous (base) year, 2004. Upon receipt of the final cost report for 2006, MAA will identify the difference between the actual cost to charge ratio and the base year cost to charge ratio. Any difference between the cost-to-charge ratio used in making inpatient payments to the hospital and the cost-to-charge ratio as actually determined for the payment year will result in an adjustment to federal payments to this hospital for inpatient services in the next fiscal year. This process will be adjusted for in the calculation of state grants due to the hospital.

_____ _____

CFO, Public Hospital Date

Medical Assistance Administration

Washington State Certified Public Expenditures Program

Operations Manual

2005 – 2007 Biennium

Appendix F

Baseline Calculation Model Example

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State of Washington
Impact Analysis - Transition from Current Reimbursement System
Five Year Impact Assessment - Assumes Year-to-Year Changes in Baseline Scenario Expenditures. "Baseline" Scenario
In-scope hospitals: public, non-border, non-critical access hospitals

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	In-Scope Costs					Payments/IP FFS *Includes FFS specific GME*					Payments - Trauma/Special					Payments - FFS Outpatient				
	A1	A2	A3	A4	A5	B1	B2	B3	B4	B5	B11	B12	B13	B14	B15	C1	C2	C3	C4	C5
	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10
CASCADE VALLEY HOSPITAL	7,371,845	7,781,240	7,790,336	8,117,022	8,460,493	1,402,244	1,489,232	1,601,058	1,681,111	1,765,167	-	-	-	-	-	1,286,491	1,345,563	1,183,585	1,225,011	1,267,886
EVERGREEN HOSPITAL MEDICAL CTR	15,595,978	16,448,643	16,507,750	17,156,512	17,821,987	5,641,334	5,991,293	6,441,180	6,763,239	7,101,401	-	-	-	-	-	1,556,864	1,628,352	1,432,332	1,482,463	1,534,350
HARBORVIEW MEDICAL CENTER	208,349,326	219,502,698	218,250,525	226,330,453	234,535,467	71,926,789	76,388,750	82,124,793	86,231,032	90,542,584	7,751,988	8,299,278	8,714,242	9,149,954	9,607,452	12,414,738	12,984,792	11,421,691	11,821,450	12,235,201
KENNEWICK GENERAL HOSPITAL	12,701,329	13,366,374	13,547,854	14,105,637	14,688,766	2,812,716	2,987,202	3,211,512	3,372,088	3,540,692	-	-	-	-	-	2,373,819	2,482,819	2,183,939	2,260,377	2,339,490
						-	-									-	-			
						-	-									-	-			
						-	-									-	-			
OLYMPIC MEDICAL CENTER	9,423,734	9,926,200	10,094,109	10,515,765	10,956,398	2,387,005	2,535,083	2,725,442	2,861,715	3,004,800	-	-	-	-	-	1,617,416	1,691,683	1,488,040	1,540,121	1,594,025
PHD #2 STEVENS HEALTHCARE	21,575,735	22,750,895	23,008,155	23,938,225	24,898,269	7,371,709	7,829,011	8,416,893	8,837,738	9,279,625	-	-	-	-	-	2,809,448	2,938,451	2,584,723	2,675,188	2,768,819
SAMARITAN HOSP - MOSES LAKE	11,712,119	12,249,654	12,616,981	13,110,385	13,621,832	2,342,608	2,487,931	2,674,750	2,808,488	2,948,912	-	-	-	-	-	1,121,916	1,173,432	1,032,175	1,068,301	1,105,692
SKAGIT CO HOSPITAL DISTRICT #2-ISLAND	3,626,207	3,808,041	3,850,443	4,004,435	4,165,415	737,356	783,097	841,900	883,995	928,195	-	-	-	-	-	589,546	616,616	542,388	561,372	581,020
SKAGIT VALLEY HOSPITAL-AFFILIATED	16,745,859	17,642,265	16,528,969	17,175,992	17,846,399	3,468,957	3,684,153	3,960,797	4,158,836	4,366,778	775	829	871	914	960	2,015,666	2,108,220	1,854,434	1,919,339	1,986,516
						-	-									-	-			
UNIV OF WASHINGTON MED CTR	95,163,379	100,309,781	102,983,158	107,100,622	111,282,224	43,516,510	46,216,046	49,686,416	52,170,737	54,779,274	-	-	-	-	-	8,036,989	8,406,028	7,394,115	7,652,909	7,920,761
VALLEY GENERAL HOSPITAL-MONROE	4,521,750	4,774,584	4,820,427	5,023,792	5,236,347	1,628,789	1,729,831	1,859,724	1,952,710	2,050,346	-	-	-	-	-	818,357	855,934	752,897	779,249	806,522
VALLEY MEDICAL CENTER-RENTON	42,463,015	44,583,562	44,871,393	46,593,906	48,373,631	9,321,806	9,900,082	10,643,481	11,175,655	11,734,438	11,088	11,871	12,465	13,088	13,742	4,106,704	4,295,274	3,778,212	3,910,449	4,047,315
WHIDBEY GENERAL HOSPITAL	6,475,315	6,796,920	6,863,987	7,135,675	7,419,252	1,060,951	1,126,767	1,211,376	1,271,945	1,335,542	1,609	1,723	1,809	1,900	1,995	777,262	812,952	715,089	740,118	766,022
TOTALS/*AVERAGES*:	**455,725,589**	**479,940,856**	**481,734,089**	**500,308,421**	**519,306,480**	**153,618,773**	**163,148,477**	**175,399,322**	**184,169,288**	**193,377,752**	**7,765,460**	**8,313,702**	**8,729,387**	**9,165,856**	**9,624,149**	**39,525,217**	**41,340,117**	**36,363,620**	**37,636,347**	**38,953,619**
DATA SOURCES AND NOTES:	152,212,884	160,128,377	160,500,406	166,877,346	173,488,789	38,175,475	40,543,682	43,588,113	45,767,519	48,055,895	13,472	14,424	15,145	15,902	16,697	19,073,490	19,949,297	17,547,814	18,161,987	18,797,657
Check:																				

State of Washington
Impact Analysis - Transition fr
Five Year Impact Assessm
In-scope hospitals: public, non-bord

Set payment to DSH limit?	*No*

"No" = DSH payments in the model are capped at SFY04 DSH payment levels.

Make supplemental payment?	*No*

"Yes" = Model generates payments subject to UPL gap for facility type and availability of UCC net of DSH payments.

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Payments limited to UCC as computed in the model; aggregate payments subject to DSH allotment constraint

Based on upper payment limit (UPL) calculation

	Payments/Managed Care *Includes managed care specific GME*					Payments - State Program					Payments - DSH					Payments - Supplemental				
	D1	D2	D3	D4	D5	E1	E2	E3	E4	E5	F1	F2	F3	F4	F5	G1	G2	G3	G4	G5
	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10
CASCADE VALLEY HOSPITAL	242,464	250,344	258,481	266,881	275,555	135,129	149,506	84,863	84,863	84,863	2,268,848	2,268,848	2,268,848	2,268,848	2,268,848					
EVERGREEN HOSPITAL MEDICAL CTR	1,313,305	1,355,987	1,400,057	1,445,558	1,492,539	221,423	244,983	139,057	139,057	139,057	5,943,014	5,943,014	5,943,014	5,943,014	5,943,014					
HARBORVIEW MEDICAL CENTER	11,561,640	11,937,394	12,325,359	12,725,933	13,139,526	3,023,887	3,345,633	1,899,049	1,899,049	1,899,049	104,694,171	106,336,389	103,664,440	106,336,389	106,336,389	-	-	-	-	-
KENNEWICK GENERAL HOSPITAL	2,685,783	2,773,071	2,863,196	2,956,249	3,052,328	196,264	217,147	123,257	123,257	123,257	3,536,231	3,536,231	3,536,231	3,536,231	3,536,231					
						-	-					-								
						-	-					-								
						-	-					-								
OLYMPIC MEDICAL CENTER	1,116,410	1,152,694	1,190,156	1,228,836	1,268,773	229,734	254,178	144,277	144,277	144,277	3,960,493	3,960,493	3,960,493	3,960,493	3,960,493					
PHD #2 STEVENS HEALTHCARE	1,227,527	1,267,422	1,308,613	1,351,143	1,395,055	320,584	354,695	201,332	201,332	201,332	5,952,022	5,952,022	5,952,022	5,952,022	5,952,022					
SAMARITAN HOSP - MOSES LAKE	3,990,260	4,119,944	4,253,842	4,392,092	4,534,835	232,363	257,087	145,928	145,928	145,928	4,257,335	4,263,918	4,263,918	4,263,918	4,263,918					
SKAGIT CO HOSPITAL DISTRICT #2-ISLAND	1,078,921	1,113,986	1,150,190	1,187,571	1,226,167	47,756	52,837	29,992	29,992	29,992	755,676	755,676	755,676	755,676	755,676					
SKAGIT VALLEY HOSPITAL-AFFILIATED	1,634,080	1,687,187	1,742,021	1,798,637	1,857,092	243,304	269,191	152,798	152,798	152,798	5,033,862	5,033,862	5,072,111	5,072,111	5,072,111					
						-	-													
UNIV OF WASHINGTON MED CTR	22,770,744	23,510,793	24,274,894	25,063,828	25,878,402	907,676	1,004,254	570,035	570,035	570,035	20,839,137	22,176,915	21,627,733	22,213,149	22,703,787	-	-	-	-	-
VALLEY GENERAL HOSPITAL-MONROE	212,659	219,570	226,706	234,074	241,682	71,818	79,460	45,103	45,103	45,103	1,861,945	1,969,249	1,981,100	2,045,719	2,045,719					
VALLEY MEDICAL CENTER-RENTON	17,056,801	17,611,147	18,183,509	18,774,473	19,384,643	481,855	533,125	302,613	302,613	302,613	7,181,997	7,181,997	7,181,997	7,181,997	7,181,997					
WHIDBEY GENERAL HOSPITAL	1,971,156	2,035,218	2,101,363	2,169,657	2,240,171	65,579	72,556	41,184	41,184	41,184	1,854,751	1,854,751	1,854,751	1,854,751	1,854,751					
TOTALS/*AVERAGES*:	**66,861,748**	**69,034,755**	**71,278,385**	**73,594,932**	**75,986,768**	**6,177,373**	**6,834,654**	**3,879,487**	**3,879,487**	**3,879,487**	**168,139,482**	**171,233,365**	**168,062,334**	**171,384,318**	**171,874,957**	**-**	**-**	**-**	**-**	**-**
DATA SOURCES AND NOTES:	32,529,365	33,586,569	34,678,132	35,805,172	36,968,840	2,245,809	2,484,767	1,410,404	1,410,404	1,410,404	42,606,174	42,720,061	42,770,161	42,834,781	42,834,781	-	-	-	-	-
											42,606,174									
											Macro DSH allotment constraint not built in									

Check:

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State of Washington
Impact Analysis - Transition fr
Five Year Impact Assessm
In-scope hospitals: public, non-bord

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Based on SFY04's ratio of (IGTs-to-nominal payments subject to IGTs)

	Intergovernmental Transfers					Net Payments (Total Payments less IGTs)					Difference, Costs to Net Payments					Cost Coverage (%)				
	H1	H2	H3	H4	H5	I1	I2	I3	I4	I5	J1	J2	J3	J4	J5	K1	K2	K3	K4	K5
	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10	SFY06	SFY07	SFY08	SFY09	SFY10
CASCADE VALLEY HOSPITAL	(1,559,644)	(1,559,644)	(1,559,644)	(1,559,644)	(1,559,644)	3,775,531	3,943,850	3,837,191	3,967,070	4,102,675	3,596,313	3,837,390	3,953,145	4,149,952	4,357,818	*51.2%*	*50.7%*	*49.3%*	*48.9%*	*48.5%*
EVERGREEN HOSPITAL MEDICAL CTR	(4,732,756)	(4,732,756)	(4,732,756)	(4,732,756)	(4,732,756)	9,943,184	10,430,873	10,622,884	11,040,576	11,477,605	5,652,793	6,017,770	5,884,866	6,115,936	6,344,382	*63.8%*	*63.4%*	*64.4%*	*64.4%*	*64.4%*
HARBORVIEW MEDICAL CENTER	(70,437,700)	(72,047,074)	(69,744,903)	(71,542,576)	(71,542,576)	140,935,513	147,245,162	150,404,671	156,621,232	162,217,625	67,413,813	72,257,535	67,845,854	69,709,221	72,317,842	*67.6%*	*67.1%*	*68.9%*	*69.2%*	*69.2%*
KENNEWICK GENERAL HOSPITAL	(2,938,638)	(2,938,638)	(2,938,638)	(2,938,638)	(2,938,638)	8,666,175	9,057,832	8,979,496	9,309,563	9,653,359	4,035,154	4,308,542	4,568,358	4,796,074	5,035,407	*68.2%*	*67.8%*	*66.3%*	*66.0%*	*65.7%*
						-	-				-	-	-	-	-					
						-	-				-	-	-	-	-					
						-	-				-	-	-	-	-					
OLYMPIC MEDICAL CENTER	(3,245,980)	(3,245,980)	(3,245,980)	(3,245,980)	(3,245,980)	6,065,079	6,348,151	6,262,428	6,489,462	6,726,389	3,358,655	3,578,049	3,831,681	4,026,303	4,230,009	*64.4%*	*64.0%*	*62.0%*	*61.7%*	*61.4%*
PHD #2 STEVENS HEALTHCARE	(4,697,765)	(4,697,765)	(4,697,765)	(4,697,765)	(4,697,765)	12,983,526	13,643,836	13,765,817	14,319,657	14,899,088	8,592,209	9,107,059	9,242,338	9,618,568	9,999,181	*60.2%*	*60.0%*	*59.8%*	*59.8%*	*59.8%*
SAMARITAN HOSP - MOSES LAKE	(2,746,427)	(2,752,122)	(2,752,122)	(2,752,122)	(2,752,122)	9,198,055	9,550,190	9,618,491	9,926,605	10,247,163	2,514,064	2,699,464	2,998,490	3,183,781	3,374,670	*78.5%*	*78.0%*	*76.2%*	*75.7%*	*75.2%*
SKAGIT CO HOSPITAL DISTRICT #2-ISLAND	(398,910)	(398,910)	(398,910)	(398,910)	(398,910)	2,810,344	2,923,302	2,921,236	3,019,695	3,122,139	815,863	884,739	929,208	984,739	1,043,276	*77.5%*	*76.8%*	*75.9%*	*75.4%*	*75.0%*
SKAGIT VALLEY HOSPITAL-AFFILIATED	(3,930,011)	(3,930,011)	(4,851,866)	(4,851,866)	(4,851,866)	8,466,632	8,853,432	7,931,166	8,250,771	8,584,391	8,279,227	8,788,832	8,597,803	8,925,221	9,262,008	*50.6%*	*50.2%*	*48.0%*	*48.0%*	*48.1%*
						-	-													
UNIV OF WASHINGTON MED CTR	(15,646,203)	(16,957,225)	(16,238,288)	(16,677,823)	(17,046,198)	80,424,852	84,356,810	86,834,254	90,499,174	94,301,496	14,738,527	15,952,971	16,148,903	16,601,449	16,980,728	*84.5%*	*84.1%*	*84.3%*	*84.5%*	*84.7%*
VALLEY GENERAL HOSPITAL-MONROE	(1,375,367)	(1,468,184)	(1,450,630)	(1,497,947)	(1,497,947)	3,218,202	3,385,859	3,414,900	3,558,908	3,691,425	1,303,549	1,388,725	1,405,528	1,464,884	1,544,922	*71.2%*	*70.9%*	*70.8%*	*70.8%*	*70.5%*
VALLEY MEDICAL CENTER-RENTON	(5,442,422)	(5,442,422)	(5,442,422)	(5,442,422)	(5,442,422)	32,717,830	34,091,074	34,659,854	35,915,853	37,222,326	9,745,185	10,492,487	10,211,539	10,678,053	11,151,305	*77.1%*	*76.5%*	*77.2%*	*77.1%*	*76.9%*
WHIDBEY GENERAL HOSPITAL	(1,249,622)	(1,249,622)	(1,249,622)	(1,249,622)	(1,249,622)	4,481,686	4,654,345	4,675,951	4,829,932	4,990,043	1,993,629	2,142,575	2,188,036	2,305,742	2,429,210	*69.2%*	*68.5%*	*68.1%*	*67.7%*	*67.3%*
TOTALS/*AVERAGES*:	**(118,401,446)**	**(121,420,354)**	**(119,303,546)**	**(121,588,071)**	**(121,956,446)**	**323,686,608**	**338,484,717**	**343,928,340**	**357,748,498**	**371,235,722**	**132,038,981**	**141,456,139**	**137,805,749**	**142,559,923**	**148,070,758**	***68.6%***	***69.0%***	***69.0%***	***69.2%***	***69.2%***
DATA SOURCES AND NOTES:	(32,317,542)	(32,416,055)	(33,320,355)	(33,367,672)	(33,367,672)	102,326,243	106,882,745	106,689,414	110,628,092	114,716,601	49,886,641	53,245,632	53,810,992	56,249,253	58,772,188					
Check:																				

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Appendix G

Program Payment and Reconciliation Timeline

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CPE PROGRAM YEAR PROCESS FLOW

FISCAL YEAR	MONTH	CAL YR	PROGRAM YEAR ONE (SFY06)	PROGRAM YEAR TWO (SFY07)	COMMENTS
FY06	7	2005	Initial SFY06 State grant payments made based on SFY06 interim baseline calculation; DSH, UPL & IP PMTS begin		SFY 06 IP PMTS will be made on a claim basis, DSH Pmts will be paid monthly, UPL will be paid monthly & 100% of State Grants will be paid in July based on interim base-line calc. MAA will pay first quarter DSH based on estimate based on prior year DSH limit and projected UCC and RCC. Sept update will adjust DSH payment for Q2-Q4 for updated DHS limit calculation.
FY06	8	2005	Interim Base-line calculations for SFY06 & SFY07 revised and sent to hospitals for review.		
FY06	9	2005	SFY06 DSH limits and payment calculations finalized. Q2-Q4 DSH adjusted as required.		Updates based on SFY04 claims, SFY04 RCC and SFY06 (SFY04 actual UCC data) LIDSH Application.
FY06	10	2005	SFY06 & SFY07 Interim Baseline appeals submitted and resolved. Interim baseline adjusted for revised trend assumption and SFY06 DSH caps.		The appeal process includes changes made in August and September. Amounts are trended forward based on caseload and inflation assumptions in the State Medical Assistance Forecast.
FY06	11	2005	Changes in projected Hold Harmless requirements for FY06-07 submitted as part of FY06-07 supplemental budget.		
FY06	12	2005	Govs budget released		
FY06	1	2006	Legislative Session		
FY06	2	2006	SFY06 & SFY 07 Interim Baseline and supplemental budget request adjusted for changes in Feb forecast of IP claims, policy changes in budget, and or data submitted by hospitals.		Update based on Feb forecast of caseload and Legs changes. Hospitals may submit claim data to support request for trend assumption be changed to reflect actual experience.
FY06	3	2006			
FY06	4	2006	Adjustments to SFY06 state grants based on revised Interim Baseline paid/recouped.		Any additional SFY 2006 state grant payment is made in April; recoupments are made through June.
FY06	5	2006			
FY06	6	2006		IP & DSH payments set for SFY07	
			PROGRAM YEAR ENDS		

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CPE PROGRAM YEAR PROCESS FLOW

FISCAL YEAR	MONTH	CAL YR	PROGRAM YEAR ONE (SFY06)	PROGRAM YEAR TWO (SFY07)	COMMENTS
FY07	7	2006		Initial SFY07 State grant payments made based on SFY07 interim baseline calculation; DSH, UPL & IP PMTS begin	SFY 07 IP PMTS will be made on a claim basis, DSH Pmts will be paid monthly, UPL will be paid monthly & 100% of State Grants will be paid in July based on interim base-line calc. MAA will pay first quarter DSH based on estimate based on prior year DSH limit and projected UCC and RCC. Sept update will adjust DSH payment for Q2-Q4 for updated DHS limit calculation.
FY07	8	2006		Interim Base-line calculations for SFY07 revised and sent to hospitals for review.	Updates based on SFY05 claims, SFY05 RCC and SFY07 (SFY05 actual UCC data) LIDSH Application.
FY07	9	2006		SFY07 DSH limits and payment calculations finalized. Q2-Q4 DSH adjusted as required.	
FY07	10	2006		SFY07 Interim Base-line appeals submitted and resolved. SFY 07 Interim Baseline and supplemental budget request adjusted for changes in Feb forecast of IP claims, policy changes in budget, and or data submitted by hospitals.	The appeal process includes changes made in August and September. Amounts are trended forward based on caseload and inflation assumptions in the State Medical Assistance Forecast.
FY07	11	2006	Information requested from hospitals to begin estimation of funding needs for final baseline calculation and payment	Changes in projected Hold Harmless requirements for SFY07 submitted as part of SFY06-07 supplemental budget.	
FY07	12	2006	Govs budget released	Govs budget released	12/31 FYE hospitals' audited 2005 Medicare cost report available
FY07	1	2007	Legislative Session - information requested from hospitals to estimate funding needs for final baseline calculation and payment	Legislative Session	Update based on Feb forecast of caseload and Legs changes. Hospitals may submit claim data to support request for trend assumption be changed to reflect actual experience.
FY07	2	2007		SFY 07 Interim Baseline and supplemental budget request adjusted for changes in Feb forecast of IP claims, policy changes in budget, and or data submitted by hospitals.	
FY07	3	2007			
FY07	4	2007	**SFY06 certification due** SFY06 Final Baseline calculated based on actual SFY06 claims data. Any state grant additional payment/ recoupment due to/from hospital identified.	Adjustments to SFY07 state grants based on revised Interim Baseline paid/recouped.	Any additional SFY 2006 state grant payment is made in April; recoupments are made through June.
FY07	5	2007			
FY07	6	2007			6/30 FYE hospitals' audited 2006 Medicare Cost report available.
				PROGRAM YEAR ENDS	

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CPE PROGRAM YEAR PROCESS FLOW

FISCAL YEAR	MONTH	CAL YR	PROGRAM YEAR ONE (SFY06)	PROGRAM YEAR TWO (SFY07)	COMMENTS
FY08	7	2007			
FY08	8	2007			
FY08	9	2007			
FY08	10	2007			
FY08	11	2007		Information requested from hospitals to begin estimation of funding needs for final baseline calculation and payment	
FY08	12	2007		Govs budget released	12/31 hospitals' audited 2006 Medicare cost reports available
FY08	1	2008		Legislative Session - information requested from hospitals to estimate funding needs for final baseline calculation and payment	
FY08	2	2008			
FY08	3	2008			
FY08	4	2008		**SFY07 certification due** SFY07 Final Baseline calculated based on actual SFY07 claims data. Any state grant additional payment/ recoupment due to/from hospital identified.	Any additional SFY 2007 state grant payment is made in April; recoupments are made through June.
FY08	5	2008			
FY08	6	2008			6/30 FYE hospitals' audited 2007 Medicare Cost report available.

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CPE PROGRAM YEAR PROCESS FLOW

FISCAL YEAR	MONTH	CAL YR	PROGRAM YEAR ONE (SFY06)	PROGRAM YEAR TWO (SFY07)	COMMENTS
FY09	7	2008			
FY09	8	2008	CMS-Prospective RCC Settlement and final Hold Harmless Adjustment completed		RCCs from audited Medicare Cost Report used to recalculate payments and determine settlement amount due to CMS. State Grants adjusted to meet hold harmless requirement. Additional payments are made in July; IP & DSH recoupments are made through an adjustment in the RCC rate for the upcoming year.
FY09	9	2008			
FY09	10	2008			
FY09	11	2008	Final Hold Harmless adjustment to SFY06 State Grants submitted as part of SFY08-09 supplemental budget		
FY09	12	2008	Govs budget released		12/31 hospitals' audited 2007 Medicare cost reports available
FY09	1	2008	Legislative Session		
FY09	2	2008			
FY09	3	2008			
FY09	4	2008			
FY09	5	2008			
FY09	6	2008	SFY06 Final State Grant Payment/Recoupment based on Cost Settlement		

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CPE PROGRAM YEAR PROCESS FLOW

FISCAL YEAR	MONTH	CAL YR	PROGRAM YEAR ONE (SFY06)	PROGRAM YEAR TWO (SFY07)	COMMENTS
FY10	7	2009			
FY10	8	2009		CMS-Prospective RCC Settlement and final Hold Harmless Adjustment completed	RCCs from audited Medicare Cost Report used to recalculate payments and determine settlement amount due to CMS. State Grants adjusted to meet hold harmless requirement. Additional payments are made in July; recoupments are made through an adjustment in the RCC rate for the upcoming year.
FY10	9	2009			
FY10	10	2009			
FY10	11	2009		Final Hold Harmless adjustment to SFY07 State Grants submitted as part of SFY08-09 supplemental budget	
FY10	12	2009		Govs budget released	
FY10	1	2010		Legislative Session	
FY10	2	2010			
FY10	3	2010			
FY10	4	2010			
FY10	5	2010			
FY10	6	2010		SFY07 Final State Grant Payment/Recoupment based on Cost Settlement	

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Appendix H

Numbered Memoranda and Billing Instruction Sections
Related to CPE

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: CPE Hospitals
Managed Care Plans

Memorandum No: 05-68 MAA
Issued: June 30, 2005

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

For More Information, call:
1-800-562-6188

Subject: **"Full Cost" Public Hospital Certified Public Expenditures (CPE) Payment Program: Update to Hospital Reimbursement Methods**

Effective July 1, 2005, MAA will pay the hospitals listed in this memorandum using the Certified Public Expenditures (CPE) methodology.

Which hospitals are affected?

Effective July 1, 2005, the Medical Assistance Administration (MAA) will reimburse the following public hospitals through the "full cost" Certified Public Expenditures (CPE) Program. State psychiatric hospitals, Western State Hospital and Eastern State Hospital, and bordering city hospitals are **not** eligible to be reimbursed through the CPE program.

- Cascade Valley Hospital (Snohomish County Public Hospital District #3)
- Evergreen Hospital Medical Center (King County Public Hospital District #2)
- Harborview Medical Center
- Island Hospital (Skagit County Hospital District #2)
- Kennewick General Hospital (Kennewick Public Hospital District)
- Olympic Medical Center (Clallam County Public Hospital District #2)
- Samaritan Healthcare (Grant County Public Hospital District #1)
- Skagit Valley Hospital (Skagit County Public Hospital District #1)
- Snoqualmie Valley Hospital (King County Public Hospital District #4)
- Stevens Healthcare (Snohomish County Public Hospital District #2)
- University of Washington Medical Center
- Valley General Hospital (Snohomish County Public Hospital District #1)
- Valley Medical Center (King County Public Hospital District #1)
- Whidbey General Hospital (Whidbey Island Public Hospital District)

How does MAA determine "full cost"?

MAA's CPE Payment Program will pay eligible public hospitals the same amount as the Medicaid federal match portion of the "full cost" of covered medically necessary inpatient services and uncompensated care. MAA uses the ratio of costs-to-charges (RCC) methodology described in WAC 388-550-4500 to determine "full cost."

How is the payment for each hospital determined?

Payments under the CPE Payment Program are paid at an estimate of the cost to provide services. The estimate of costs for inpatient claims is determined by the RCC methodology using a base year, usually two years before the service year. For each payment to a hospital in the program, only the federal matching portion of the payment is made; the state portion is funded through CPE.

Disproportionate Share Hospital (DSH) payments to a hospital for uncompensated care are made at the hospital's DSH cap, calculated according to federal requirements. Hospitals are paid only the federal matching portion of the payments.

For Harborview Medical Center (HMC), the upper payment limit (UPL) is calculated at the full amount the hospital must receive to meet the state's "hold harmless" provision. Federal matching funds are paid with state general funds, for the full payment amount.

State grant payments may be made to hospitals to ensure that the "hold harmless" provision is met.

What is the "hold harmless" provision?

The CPE Payment Program has a state mandate for a "hold harmless" provision. Each hospital must be paid at least as much money as it would have received from state funds as it would have received under the methodology in place in state fiscal year 2005. The amount of money equal to "what hospital would have been paid" is referred to as the "baseline."

Why is a prospective cost settlement process necessary?

Prospective cost settlement ensures a full cost basis and avoids recoupment of federal money years after a payment is made.

The state's "hold harmless" provision is ensured through a final calculation of the hospital's baseline, completed at the same time as the prospective cost settlement. Any change in federal funding is offset by an opposite change in the hospital's state grant or UPL payment, to ensure that the hospital receives the full baseline payment for the service year.

Effective July 1, 2005, inpatient hospital admissions that exceed the Professional Activities Study (PAS) Length of Stay (LOS) are incorporated into the annual retrospective review.

Effective July 1, 2005, in conjunction with the implementation of the CPE Payment Program, MAA will no longer perform utilization reviews of inpatient hospital admissions that exceed the PAS average length of stay (LOS) prior to claim payment. Reviews of admissions that exceed PAS LOS will be incorporated into the annual retrospective review conducted by MAA's Hospital Utilization Review Unit of the Office of Payment Review and Audit.

How can I get more information on Washington's CPE Program?

For more information, please refer to the "CPE Operating Manual" for the Washington State CPE Payment Program. It is available on MAA's website on the Hospital Reimbursement Information page at the following address:

http://fortress.wa.gov/dshs/maa/hrates/Main%20Menu/index.html

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the Billing Instructions/Numbered Memoranda or Provider Publications/Fee Schedules link).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (orders filled daily).

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance.***

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

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Appendix I

Hold Harmless RCC Rates for FY 2006

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Hold Harmless Rates: Certified Public Expenditures Program

Effective Date: August 1, 2005

First Posted: July 14, 2005
Last Update:

This is the Proposed Notice for rates required under WAC 388-550-550. These rates are required by the "hold harmless" provisions of the Certified Public Expenditures (CPE) program.

The CPE program has a State mandate for a hold harmless provision. Under this provision, each hospital must be paid at least as much money by the State as they would have received under the methodology in place in 2005—including RCC, DRG, selective contract, or whatever combination of methodologies are used to pay the hospital. The amount of money equal to "what the hospital would have been paid" is referred to as the "baseline". The state hold harmless requirement is ensured through a final calculation of the baseline, completed at the same time as the prospective cost settlement. Any changes in federal funding are offset by an opposite change in the hospital's state grants or Upper Payment Limit (UPL) payment, to ensure that the hospital receives the full baseline payment for the service year.

For more information on the CPE program, including "hold harmless" provisions, please refer to the "CPE Operating Manual" at the following website address: http://fortress.wa.gov/dshs/maa/hrates/Main%20Menu/index.html

These rates reflect vendor rate increases granted by the legislature where applicable. The increase is calculated in accordance with the mandate in the 2005 – 2007 Biennial Operating budget, ESSB 6090 sec. 209(12), which states in part: "… increases shall be provided only on the portion of a hospital's rate that excludes medical education and outlier costs, and shall be allocated so that hospitals with lower costs of care … receive larger percentage increases than those with higher costs of care."

	Inpatient DRG		Inpatient RCC		Inpatient Outlier	
HOSPITAL	**Medicaid**	**GAU/PII**	**Medicaid**	**GAU/PII**	**Medicaid**	**GAU/PII**
Cascade Valley Hosp	$3,669	$1,292	48.6	27.0	36.4	16.2
Evergreen Hosp Med Ctr	$4,105	$853	58.2	21.1	43.6	12.7
Harborview Medical Center	$5,515	$2,121	53.5	40.2	40.1	24.1
Kennewick General Hospital	$3,826	$907	42.8	18.1	32.1	10.9
Olympic Medical Center	None	$1,392	61.2	42.5	None	25.5
Samaritan Hospital	None	$1,483	44.0	26.5	None	15.9
Snoqualmie Hospital	None	$1,648	100.0	70.1	None	42.0
Island Hospital	$4,495	$1,114	44.3	24.3	33.2	14.6
Skagit Valley Hospital	$3,596	$1,318	51.7	27.1	38.8	16.2
Stevens Memorial Hospital	$4,544	$1,147	46.1	22.5	34.6	13.5
U of W Medical Ctr	$5,681	$1,441	57.1	25.5	42.8	15.3
Valley General Hosp	$4,237	$978	64.7	27.7	48.5	16.6
Valley Medical Ctr	$4,304	$1,077	44.3	19.4	33.2	11.6
Whidbey General Hosptal	None	$1,483	54.5	32.8	None	19.7